Official Questions Answers for
RFP-2019-OMS-02-MANAG
Medicaid Care Management Services

ID	Reference	Category	Respondent Question	DHHS Response
001		Rates and Payments	When will information for the State Fiscal Year 2020 and 2021 become available?	Draft capitation rate reports are typically released to participating MCOs 2-4 months before they are effective.
002		Rates and Payments	Do you anticipate the capitation rates for State Fiscal Year 2020 and 2021 will be available before the Request for Proposal response due date?	No, DHHS will develop actuarially sound capitation rates for the first year of the contract (July 1, 2019 – June 30, 2020) after MCO selection, MCO contract execution, and the Governor and Executive Council approval.
003		Rates and Payments	Is there a standard process to set the rates, such as a meeting with the actuaries to go through data?	DHHS and its actuaries work collaboratively with the MCOs to collect, validate, and understand the historical data used for rate development. A detailed draft rate report is released to participating MCOs, followed by a in-person meeting to discuss the details of the rate development process and rating assumptions as well as answering MCO questions. A final rate report is then issued for contract signature.
004		Rates and Payments	Do you have a date when the draft MCM Withhold and Incentive Guidance will be finalized?	The final Withhold and Incentive Guidance is available as a reference document to the RFP on the DHHS website: https://www.dhhs.nh.gov/business/rfp/rfp-2019-oms-02-manag.htm
005	RFP-SEC4-Fig3	Pharmacy	Regarding RFP Figure 3 RFP Section 4 Pharmacy Management, will the preferred drug list (PDL) be released prior to the RFP response submission?	DHHS' PDL is posted on the DHHS pharmacy website: https://www.dhhs.nh.gov/ombp/pharmacy/index.htm.
006		Cost Component - RFP	Is there any guidance on how cost component points will be assigned?	The point assignment is outlined in the RFP Figure 4 Cost Components Evaluation Criteria.
007	RFP-SEC?-Fig4	Care Management	In the RFP Figure 4 asking for administrative expenses, is the 50% of care management to be delivered by local care management entities to be included in the totals?	All estimated SFY 2020 MCO administrative costs should be included in Table F found in Appendix E-1 "RFP Cost Component Questions Excel Template", including care management services delegated to Local Care Management entities. Respondents should include a description of the treatment of Local Care Management entity costs in the narrative description requested in Part 3 of Question 126 in Appendix E. Note that case management services that are billed by qualifying providers as a service should be excluded from administrative costs.
008		Enrollment	For new plans entering, there are questions on how enrollment will build up. Any additional enrollment information is requested.	The program structure implemented by DHHS to meet its commitment to providing new entrant(s) with the ability to achieve an equitable share of MCM Members within twelve (12) to eighteen (18) months of program (as described in Section 2.2.2.1 of the RFP and 5.2.1 of Appendix D) will vary based on the MCOs selected; DHHS anticipates working collaboratively with selected MCOs to meet this commitment and will provide further information when available.
009		Pharmacy	Will specialty pharmacy carve outs be released before RFP response submission, or will this be part of the negotiation?	No, the actual carve outs will be based on future actuarial driven determinations as part of rate setting. The current (2018) NDC list of carved out drugs is in the SFY 2019 MCM Rating Document- Appendix J. These include drugs to treat Hepatitis C and hemophilia (POS claims only), and the drugs Carbaglu and Ravicti.
010		Enrollment	Regarding the new population beginning on January 1, 2019, will there be a release of data on this population?	CY2016 and CY2017 Premium Assistance Program (PAP) Cost Models is available as a reference document to the RFP on the DHHS website: https://www.dhhs.nh.gov/business/rfp/rfp-2019-oms-02-manag.htm
011		Technical - RFP	Would the RFP Q&A release be delayed if only a few questions still need to be answered?	Yes.
012		Rates and Payments	Will the Department continue to pay the MCOs three months in arears?	See Appendix C – Medicaid Care Management Services Model Contract Section 6.2.9 which states, "DHHS will make a monthly payment to the MCO for each Member enrolled in the MCO's plan as DHHS currently structures its capitation payments. Specifically, the monthly capitation payments for standard Medicaid will be made retrospectively with a three (3) month plus five (5) business day lag (for example coverage for July 1, 2019 will be paid by the 5th business day in October, 2019). Capitation payments for all Granite Advantage Members will be made before the end of each month of coverage."

Official Questions Answers for
RFP-2019-OMS-02-MANAG
Medicaid Care Management Services

ID	Reference	Category	Respondent Question	DHHS Response
013		Rates and Payments	Will the Department start paying using the industry standard 820 format?	DHHS estimates an implementation date to coincide with the Program start, this will be reviewed as part of readiness.
014	6.9.2 - Year 1 MCM Withhold and Incentive guidance, pgs 3 & 4, 3.2 - Performance Standards, Figure A Minimum Performance Standards	Rates and Payments	When does DHHS intend to finalize the Quality Withhold and Incentive measures' minimum performance rates and when will these standards be available to MCOs?	The final Withhold and Incentive Guidance is available as a reference document to the RFP on the DHHS website: https://www.dhhs.nh.gov/business/rfp/rfp-2019-oms-02-manag.htm
015	6.9.2 - Year 1 MCM Withhold and Incentive guidance, pg 4, 3.2 - Performance Standards, Figure A Minimum Performance Standards	Performance	The second behavioral health performance measure suggests the measurement will be taken at a point in time. Is that DHHS' intent or will the performance measure be refined to evaluate the MCOs' performance over a period of time?	The measure would be the average over the program year period.
016	Appendix C - Medicaid Care Management Services Model Contract, Pg 47, 3.10 - Organization Requirements, 3.10.6 - Background Checks and Screenings	Program Integrity	Would DHHS consider revising to quarterly instead of monthly? For those services delegated to Subcontractors and Contractors, can the MCO delegate background checks and screenings to the Subcontractor and Contractor with MCO having oversight?	CMS recommends monthly OIG screenings of employees. This can be delegated to the contractor to perform, but the MCO needs to maintain monitoring and oversight that it is being completed and reviewed.
017	Appendix C - Medicaid Care Management Services Model Contract, pg 59, 3.14.3 - Notice and Approval, 3.14.3.1	Technical - Contract	Can DHHS please clarify its definition of "subcapitated Providers"?	Refer to Addendum #1.
018	Appendix C - Medicaid Care Management Services Model Contract, pgs 65-66, 3.15 - Staffing, 3.15.2.2 - Other MCO Required Staff	Psychiatric Boarding	Could DHHS please define what "Provider" means and include clinical credentials and licensure requirements? "3.15.2.2 Behavioral Health Clinical Providers to Minimize Psychiatric Boarding: The MCO must supply a sufficient number of hospital credentialed Providers in order to provide assessments and treatment for Members who are subject to or at risk for Psychiatric Boarding. The number of such hospital-credentialed Providers must be sufficient to provide initial on-site assistance within twelve (12) hours of a Member arriving at an ED and within twenty-four (24) hours of a Member being placed on observation or inpatient status to await an inpatient psychiatric bed. The initial on-site assistance provided within these required timelines must include a beneficiary-specific plan for discharge, treatment, admittance or transfer to New Hampshire Hospital, or another Designated Receiving Facility. Each such hospital-credentialed Provider must have the clinical expertise to reduce Psychiatric Boarding and possess or be trained on the resources, including local community resources, that can be deployed to discharge the Member safely to the community or to a step down facility when an inpatient stay is not clinically required."	Providers include, but are not limited to, any NH Medicaid recognized provider types who are licensed and/or designated to treat individuals who are experiencing a behavioral health crisis.
019	Appendix C - Medicaid Care Management Services Model Contract, pgs 65 & 66, 3.15.2 - Other MCO Required Staff, 3.15.2.2	Psychiatric Boarding	Will DHHS provide clarity on the Department's position surrounding ED Boarding and if there will be any relief to the MCOs if hospitals are unwilling to participate in this program? Will there be a penalty to the MCOs in this scenario?	The Appendix C represents DHHS' expectation for MCO performance; Exhibit N accurately reflects the range of liquidated damages.
020	Appendix C - Medicaid Care Management Services Model Contract, pg 84, 4.2 - Pharmacy Mgmt, Entire Section	Pharmacy	When does DHHS intend to release the State PDL to allow for MCOs to respond to pharmacy related questions in the RFP/Cost Component?	DHHS's PDL is posted on the DHHS pharmacy website: https://www.dhhs.nh.gov/ombp/pharmacy/index.htm.

Official Questions Answers for
RFP-2019-OMS-02-MANAG
Medicaid Care Management Services

ID	Reference	Category	Respondent Question	DHHS Response
021	Appendix C - Medicaid Care Management Services Model Contract, pg 169, 4.9 - Member Education & Incentives, 4.9.4.5 Healthy Behavior Incentive Programs, 4.9.4.5.1	Incentive Programs	Do MCOs need to develop incentive programs for each of the seven areas or are MCOs permitted to submit one key focus area to meet the requirement?	No. Though relative MCO performance for earning incentives (monetary or future preferential auto assigning) could be affected based on relative comparative outcomes of an MCO that elects additional ones and achieves favorable results.
022	Appendix C - Medicaid Care Management Services Model Contract, pg 173, 4.10 - Care Coordination & Care Mgmt, 4.10.2 - Health Risk Screening, 4.10.2.3	Care Management	Can DHHS confirm that the HRAS mailing will be considered one attempt?	Mailing of the HRAs is not considered an attempt to contact a member by phone.
023	Appendix C - Medicaid Care Management Services Model Contract, pg 173, 4.10 - Care Coordination & Care Mgmt, 4.10.2 - Health Risk Screening, 4.10.2.5	Care Management	Can DHHS clarify if they expect the MCOs to share the results of the HRAS with another MCO should the member transition to another MCO in the future? If so, what is the expectation on the process of how this data would be shared?	DHHS expects MCOs to share the results of HRAs when members transition to another MCO. The process of data sharing is two-fold: a copy of the completed HRAs should be provided to the new MCO and be part of a transition of care meeting between the two MCOs for high risk, high cost members, members receiving care management and members with rising risk.
024	Appendix C - Medicaid Care Management Services Model Contract, pg 175, 4.10 - Care Coordination & Care Mgmt, 4.10.3 - Priority Populations, 4.10.3.1.1.4	Care Management	Can DHHS define "Rising risk" to ensure consistency among MCOs for reporting purposes?	DHHS is not defining rising risk. The MCO will define rising risk and the criteria used to establish the definition. DHHS will review and approve one standard definition of rising risk in collaboration with all MCOs and DHHS to be used for consistency.
025	Appendix C - Medicaid Care Management Services Model Contract, pg 180, 4.10 - Care Coordination & Care Mgmt, 4.10.6 - Care Mgmt for High Risk and High Need Members, 4.10.6.2	Care Management	Please confirm that the 15% of high risk/high need members will consist of a combination of members who are enrolled, attempted to enroll, or opt-out. Please confirm that the 15% is of the priority population and not the entire Medicaid population.	DHHS expects that 15% of each MCO's membership falls into the category of priority population and it is this group that should be targeted for care management. Care management reporting will include members enrolled, attempted to enroll, opted out and members not yet contacted.
026	Appendix C - Medicaid Care Management Services Model Contract, pg 184, 4.10 - Care Coordination & Care Mgmt, 4.10.8 - Local Care Mgmt, 4.10.8.6	Care Management	Section 4.10.8.6 indicates that IDNs will be certified as local care management entities by DHHS. Can DHHS clarify what other certification types and their entities the IDNs will required to achieve?	DHHS is defining a certification protocol for IDNs.
027	Appendix C - Medicaid Care Management Services Model Contract, pg 288, 5.3.2 - Fraud, waste and Abuse, 5.3.2.2.4.4	Program Integrity	When can DHHS provide additional detail on the three (3) data analytic algorithms for fraud detection specified by DHHS Program Integrity in order to respond to the question in the RFP?	DHHS' Program Integrity Unit will work with the MCOs to implement these algorithms. For Question 91 in Appendix D, MCOs should describe the three potential algorithms for fraud detection that they would implement.

Official Questions Answers for
RFP-2019-OMS-02-MANAG
Medicaid Care Management Services

ID	Reference	Category	Respondent Question	DHHS Response
028	Appendix C - Medicaid Care Management Services Model Contract, pg 290, 5.3.2 - Fraud, Waste & Abuse, 5.3.3 - Identification and Recoveries of Overpayments, 5.3.3.2	Program Integrity	How does the Department suggest we comply with the conflicting contract terms outlined below? Under the Medicaid Model Contract, Section 5.3.3.2, the MCO must collect all overpayments from a Provider within sixty (60) calendar days from the date the overpayments were identified and made known to the Provider. This directly conflicts with the requirements under Section 4.6.2.1 for Provider Appeals which states, the Provider has the right to file an appeal and utilize the Provider Appeal Process, including the right to request a State Fair Hearing in accordance with NH RSA 126-A:5, VIII, for any "Adverse Action" including "Action against the Provider for reasons related to Program Integrity." Under the Provider Appeal Process, a Provider has thirty (30) days from the date of the MCO's determination to file an appeal, and the MCO has 30 days to provide a written notice of resolution. If the Provider requests a fair hearing, the DHHS Administrative Appeals Unit has sixty (60) days from the date of the MCO's determination to notify the MCO of its determination. Under this process, the Plan would not be able to comply with Section 5.3.3.2 by collecting the overpayments within the sixty (60) day timeframe. This would subject the Plan to possible sanctions by the Department under the Contract	If the Provider completes a request for appeal after receiving the notification from the MCO for recovery, the MCO waits for the final determination from the appeals hearing to proceed with collection of overpayment if decision is upheld.
029	Appendix D - Mandatory Responses to Technical Components of the RFP, 1.1 - corporate Overview, 1- Organization Overview and Overview of Relevant Experience, Q1 #7	Technical - RFP	Section 1, Organization Overview and Overview of Relevant Experience is allotted a total of 7 pages. Question 1.7 asks the Respondent to provide information regarding the Respondent's major government and private sector clients. Is this request specific to the Respondent, or should this include the Respondent's parent, affiliates or subsidiaries. If the latter, please confirm this may be provided in table format and appended to the response.	Question 1.7 should include the Respondent's parent, affiliates or subsidiaries. This may be provided in table format and appended to the response.
030	Appendix D - Mandatory Responses to Technical Components of the RFP, 1.2 - Managed Care Experience & References, 1- Organization Overview and Overview of Relevant Experience, Q2	Technical - RFP	As the term "managed care services" encompasses vastly different populations, please confirm the State is only seeking examples of experience serving Medicaid populations that directly relate to this RFP, as indicated in subpart 1.	Yes, DHHS is only seeking examples of experience serving Medicaid populations that directly relate to this RFP.
031	Appendix D - Mandatory Responses to Technical Components of the RFP, 1.2 - Managed Care Experience & References, 1- Organization Overview and Overview of Relevant Experience, Q3	Technical - RFP	In order to ensure references listed will be available and can dedicate the time needed to provide all information required, can DHHS please provide additional clarification on the timeframe for when they intend to outreach to the references? In addition, can DHHS please provide additional detail regarding the format in which the references will be required to provide information?	DHHS will contact references between when bids are submitted and selection is awarded. The format is determined by DHHS.
032	Appendix D - Mandatory Responses to Technical Components of the RFP, 1.2 - Managed Care Experience & References, 1- Organization Overview and Overview of Relevant Experience, Q5	Technical - RFP	Please confirm the lookback period for question 5 should be three (3) years, in following with the instruction in question 4.	Refer to Addendum #1.

Official Questions Answers for
RFP-2019-OMS-02-MANAG
Medicaid Care Management Services

ID	Reference	Category	Respondent Question	DHHS Response
033	Appendix D - Mandatory Responses to Technical Components of the RFP, 1.2 - Managed Care Experience & References, 1- Organization Overview and Overview of Relevant Experience, Q5	Technical - RFP	Please confirm DHHS is requesting non-renewal or early termination details for Respondent only.	Yes.
034	Appendix D - Mandatory Responses to Technical Components of the RFP, 3 & 39, 1.2 - Managed Care Experience & References, 1- Organization Overview and Overview of Relevant Experience, Q4, 20 - Oversight and Accountability Q 88	Technical - RFP	Q4 on page 3 of Appendix D and Q88 on page 39 of Appendix D appear to be requesting much of the same information. Q4 requests three (3) years' worth of non-compliance issued, and Q88 requests five (5) years' worth of punitive action. Will DHHS consider combining the two questions into one question, and/or standardize the look back period? In addition, please confirm the information requested can be provided in table format and therefore appended as an attachment.	No, DHHS will not consider revising the questions. The Respondent may provide table format.
035	Appendix D - Mandatory Responses to Technical Components of the RFP, pg 5, 2 - Subcontractors, Q10 #1	Technical - RFP	Can DHHS define "amount" in this request? Are they looking for the amount of the services or the amount we pay them for these services? Also, is this on an annual timeframe or by PMPM?	"Amount" is defined as level of services provided by the subcontractor. For example, whether the contracted services are limited to State Plan services in amount, duration and scope.
036	Appendix D - Mandatory Responses to Technical Components of the RFP, pg 31, 15.1 - Health Plan Accreditation, 15 - Quality Mgmt, Q69	Technical - RFP	Question 69 indicates to provide health plan accreditation status for all markets in which it is currently participating. Will DHHS please clarify "all markets"? Is this Respondent and Medicaid Managed Care health plan affiliates in other states?	Yes. The Respondent should provide health plan accreditation status for Medicaid Managed Care health plans by state market.
037	Appendix D - Mandatory Responses to Technical Components of the RFP, pg 32, 15.2 - Quality Assessment and Performance Improvement Program, 15 - Quality Mgmt, Q73	Technical - RFP	Could DHHS please clarify if the Respondent needs to submit three other Medicaid contracts for HEDIS/CAHPS results if we are already doing business for NH Medicaid?	NH Medicaid results can count as one (1) of the required Medicaid contracts for HEDIS/CAHPS results.
038	Appendix D - Mandatory Responses to Technical Components of the RFP, pg 35, 17 - Alternative Payment Models, Q77 #6	Technical - RFP	Q.77 requires the Respondent to articulate how they will be transparent in contracting with Providers and how they will be transparent with DHHS including subparts 1-8. Are sub-parts 5 and 6 actually supposed to be combined? In addition, can DHHS please provide clarity on sub-part 6 which indicates "for the development of an performance under the MCOs proposed APM Models"?	For Q1, no. Subpart 5 is a description of how a cost target will be developed/assessed. Subpart 6 is the detail use and cost information to help a provider with managing to a target. For Q2, refer to Addendum #1.
039	Appendix D - Mandatory Responses to Technical Components of the RFP, pg 38, 19 - Claims Quality Assurance and Reporting, Q87	Technical - RFP	Question 87 in Section 19 (Claims Quality Assurance and Reporting) instructs Respondents to provide a table listing for ALL Medicaid managed care contracts in the last 5 years pertaining to encounter data submission quality/compliance. Please confirm if Respondents who are incumbents with an existing Medicaid managed care contract with DHHS should provide a table listing limited to our existing Medicaid managed care contract with DHHS ?	All Respondents should supply information for all plans and not limit their response.

Official Questions Answers for
RFP-2019-OMS-02-MANAG
Medicaid Care Management Services

ID	Reference	Category	Respondent Question	DHHS Response
040	Appendix D - Mandatory Responses to Technical Components of the RFP, pg 38, 19 - Claims Quality Assurance and Reporting, Q85	Technical - RFP	Please confirm documentation requested in Q.85. would be considered as allowable material which can be appended and not count toward the assigned page limit as outlined on page 31 (5.2.2) of the RFP.	The Respondent must comply with page limits.
041	Appendix D - Mandatory Responses to Technical Components of the RFP, pg 39, 20 - Oversight and Accountability, Entire Section	Technical - RFP	Section 20 contains ten questions and has a five page limit. Considering the number of questions and the sub-parts to those questions, would DHHS consider increasing the 5 page limit to allow the Respondent to provide complete responses to all information requested?	No.
042	Appendix E - Mandatory Responses to Cost Components of the RFP, RFP Cost Component Questions Excel Sheet, Admin	Cost Component - RFP	When will DHHS be providing capitation rates to the MCOs? Additionally, when does DHHS anticipate engaging the MCOs in rate negotiations?	The Department will develop actuarially sound capitation rates for the first year of the contract (July 1, 2019 – June 30, 2020) after MCO selection, MCO contract execution, and the Governor and Executive Council approval. The draft SFY 2020 capitation rates will be presented to the MCOs in Spring 2019.
043	Appendix E - Mandatory Responses to Cost Components of the RFP, 1, 1 - Managed Care Savings Opportunities, Q107	Cost Component - RFP	Will DHHS define "avoidable hospital readmissions" so that there will be meaningful comparisons among the bidders?	An avoidable hospital readmission occurs when a patient who has been discharged from a hospital (admission 1) is admitted again within a certain time interval and the readmission: •Is clinically related to admission 1, and •Has the potential to be avoided through improved clinical management and/or appropriate discharge planning, transition processes, community based treatment, and/or patient self-management coaching, education, and support in the admission 1.
044	Appendix E - Mandatory Responses to Cost Components of the RFP, 1 & 2, 1 - Managed Care Savings Opportunities, Q108	Cost Component - RFP	Will DHHS define "avoidable hospital admissions" so that there will be meaningful comparisons among the bidders?	Avoidable hospital admission refers to an admission to an inpatient bed that may not have been required had the acute illness been managed successfully by care professionals in outpatient settings.
045	Appendix E - Mandatory Responses to Cost Components of the RFP, 4, 1 - Managed Care Savings Opportunities, Q120	Cost Component - RFP	Please confirm the reference of Section 11 of the Technical Proposal should be Appendix D and not Appendix E	Refer to Addendum #1.
046	Appendix E - Mandatory Responses to Cost Components of the RFP, RFP Cost Component Questions Excel Sheet, MC Savings Tab, Table A	Cost Component - RFP	Please confirm that the information provided in Table A will not be made public if marked as confidential and proprietary information.	See Section 4, Proposal Process, Subsection 4.13, Public Disclosure.
047	Appendix E - Mandatory Responses to Cost Components of the RFP, RFP Cost Component Questions Excel Sheet, Entire Section	Cost Component - RFP	Can DHHS provide additional detail on how Appendix E will be evaluated? Is there a rating scale, or evaluation criteria that can be provided?	The evaluation criteria is outlined in Figure 4 Cost Components Evaluation Criteria.
048	Exhibit O - Quality and Oversight Reporting Requirements, pg 13, HRA.04, Care Mgmt, Health Risk Assessment: Best Effort to Have Member Conduct…	Quality	Can DHHS please confirm that the HRA.04 in Exhibit O is replacing the current measure HNA.01?	The measures are similar, but have differences. DHHS' quality team is currently working through all new and revised specifications. Exhibit O meetings will begin in advance of the projected 7/1/19 start date.

Official Questions Answers for
RFP-2019-OMS-02-MANAG
Medicaid Care Management Services

ID	Reference	Category	Respondent Question	DHHS Response
049	Exhibit O - Quality and Oversight Reporting Requirements, pg 13, HRA.05, Care Mgmt, Health Risk Assessment: New Member Successfully…	Quality	Can DHHS please confirm that the HRA.05 in Exhibit O is replacing the current measure HNA.07?	The measures are similar, but have differences. DHHS' quality team is currently working through all new and revised specifications. Exhibit O meetings will begin in advance of the projected 7/1/19 start date.
050	Exhibit O - Quality and Oversight Reporting Requirements, pg 40, BHREADMIT.05, Mental Health, Community Hospital Readmissions for Mental Health Conditions: Within 30 Days by Subpopulation	Quality	Can DHHS please confirm that the BHREADMIT.05 in Exhibit O is replacing the current measure BHREADMIT.03 measure marked as R19 in the current version of Exhibit O?	The measures are similar, but have differences. DHHS' quality team is currently working through all new and revised specifications. Exhibit O meetings will begin in advance of the projected 7/1/19 start date.
051	Exhibit O - Quality and Oversight Reporting Requirements, pg 40, BHREADMIT.06, Mental Health, Community Hospital Readmissions for Mental Health Conditions: Within 180 Days by Subpopulation	Quality	Can DHHS please confirm that the BHREADMIT.06 in Exhibit O is replacing the current measure BHREADMIT.04 measure marked as R19 in the current version of Exhibit O?	The measures are similar, but have differences. DHHS' quality team is currently working through all new and revised specifications. Exhibit O meetings will begin in advance of the projected 7/1/19 start date.
052	Exhibit O - Quality and Oversight Reporting Requirements, pg 49, NHHREADMIT.10, Mental Health, NHH Readmissions Within 30 Days by Subpopulation	Quality	Can DHHS please confirm that the NHHREADMIT.10 in Exhibit O is replacing the current measure BHREADMIT.05 in the current version of Exhibit O?	The measures are similar, but have differences. DHHS' quality team is currently working through all new and revised specifications. Exhibit O meetings will begin in advance of the projected 7/1/19 start date.
053	Exhibit O - Quality and Oversight Reporting Requirements, pg 49, NHHREADMIT.11, Mental Health, NHH Readmissions Within 180 Days by Subpopulation	Quality	Can DHHS please confirm that the NHHREADMIT.11 in Exhibit O is replacing the current measure BHREADMIT.06 in the current version of Exhibit O?	The measures are similar, but have differences. DHHS' quality team is currently working through all new and revised specifications. Exhibit O meetings will begin in advance of the projected 7/1/19 start date.
054	NH MCM RFP, pg 12, 2.3 - Overview of Key MCM Model Contract Components, Figure 2	Pharmacy	Will DHHS send the State Fiscal Year 2018 list of drugs currently carved out of the MCM program to the Respondent's prior to the RFP submission date?	The current (2018) NDC list of carved out drugs is in the SFY 2019 MCM Rating Document- Appendix J. These include drugs to treat Hepatitis C and hemophilia (POS claims only), and the drugs Carbaglu and Ravicti.
055	NH MCM RFP, pg 24, 4.5 - RFP and MCM Contract Amendment, 4.5.1	Technical - RFP	Should DHHS deem it necessary to amend the RFP, MCM Model Contract or any other related RFP document, would DHHS consider doing it in redlined format or sending amendment pages describing the amended language?	DHHS would provide the amended language in an Addendum.
056	NH MCM RFP, pg 29, 4 - Proposal Process, 4.21.1 - Respondent Readiness	Technical - RFP	Please confirm that the implementation plan outlined in Section 4.21.1 is to be provided as part of readiness and should not be submitted as part of the RFP response.	Refer to Addendum #1.
057	NH MCM RFP, pg 30, 5 - Proposal Requirements, 5.1 - Presentation and Identification, 5.1.1.6	Technical - RFP	5.1.1.6 indicates that the Proposal must be signed in the manner described in section 5.3.3.2, but there is no other reference to 5.3.3.2 in the RFP document. Can DHHS please provide the correction section reference?	Refer to Addendum #1.

Official Questions Answers for
RFP-2019-OMS-02-MANAG
Medicaid Care Management Services

ID	Reference	Category	Respondent Question	DHHS Response
058	NH MCM RFP, pg 30, 5 - Proposal Requirements, 5.1.2 - Presentation of submissions, 5.1.2.1 & 5.1.3.1	Technical - RFP	Part 5.1.2.1, 5.1.3.1 and 5.1.3.3 Does DHHS want the original technical and cost proposal to be provided in separate 3-ring binders with separate covers indicating Original Technical Proposal and Original Cost Component – or should they be provided together? Does DHHS want the copies of the technical and cost proposal to be provided in separate 3 ring binders with separate covers?	Refer to Addendum #1.
059	NH MCM RFP, pg 30, 5 - Proposal Requirements, 5.1 - Presentation of Identification, 5.1.1 - Overview, 5.1.1.1	Technical - RFP	5.1.1.1 Indicates that "Failure to observe the terms and conditions in completion of the Proposal are at the Respondent's risk and may, at the discretion of the State, result in disqualification of the Proposal for non-responsiveness. Can DHHS please confirm this is in reference to completion of Appendix A?	Confirmed.
060	NH MCM RFP, pg 31, 5.1.3 - Technical and Cost Proposal, 5.1.3.5, 5.1.3.5.3	Technical - RFP	Can DHHS please clarify that 5.1.3.5.3 should be either Technical Proposal, Cost Proposal or Addenda to Technical Proposal?	Refer to Addendum #1.
061	NH MCM RFP, pg 31, 5.2 - Technical Proposal Special Instructions, Figure 6 Special Instructions	Technical - RFP	All of section 1 of appendix D is allotted a total of 7 pages. Please confirm that the resumes and qualifications of key personnel can be appended to the response and not included in the page limit.	Yes.
062	NH MCM RFP, pg 33, 5.3 - Outline and Detail, Entire Section	Technical - RFP	Section 5.3 provides information on what each proposal should contain which includes the Table of Contents, Transmittal Cover Letter, Executive Summary of Proposal, Appendix D and Appendix E – however, DHHS does not provide guidance as to the outline and detail of information requested outside of those components outlined in Section 5.3. In what order does DHHS want information requested in Section 5.4 Subcontractors and Section 5.5, License Certificates and Permits as required?	Information in Section 5.4 and 5.3 should be presented at the end of the proposal under separate tabs for each of the respective sections.
063	NH MCM RFP, pg 35, 5.3 - Outline and Detail, 5.3.1.3 - Executive Summary of Proposal, 5.3.1.3.1.2	Technical - RFP	It appears that a word is missing in this question/requirement. Can DHHS provide the missing word or provide clarification? "Demonstrates the Respondent's understanding of the services requested in this RFP and MCM contract any problems anticipated in accomplishing the work".	Refer to Addendum #1.
064	NH MCM RFP, pg 39, 5.7 - Contract Terms, Conditions, and Liquidated Damages, Forms, 5.7.1 - Contract Terms and conditions, 5.7.1.1.1	Rates and Payments	There are references throughout the RFP that indicating the model contract may be revised depending on negotiations. Can DHHS confirm that the Respondent's will be afforded discussion and potential revision of the Appendix C MCM Model Contract, including the Liquidated Damages Matrix and the Draft MCM Withhold and Incentives Guide throughout the negotiation period?	In accordance with the RFP 3.1.4.5 and 4.5, DHHS reserves the right to amend the Model Contract.
065	4.3.2.1 MCO Role in Work and Community Engagement Requirements for Granite Advantage Members, pg 93	Appeals	So that the MCO can assist Members with appealing eligibility determinations for the Work and Community Engagement requirements, please provide DHHS' appeal process.	Information is accessible at the DHHS website: https://www.dhhs.nh.gov/oos/aau/appeals.htm.
066	Model Contract 4.7.3 Time and Distance Standards, pgs 143-144	Network Management	Please provide Adult Specialty Provider Types.	Adult Specialty Providers include but are not limited to: Allergist, Audiology, Cardiologist, Chiropractor, Family Planning, Neurologist, Obstetrician/Gynecologist or Other Maternity Provider, Oncologist, Ophthalmologist Orthopedist, Otolaryngologist, Plastic Surgeon, Podiatry, Psychiatrist, Thoracic Surgeon, and Urologist.
067	Model Contract 4.7.3 Time and Distance Standards, pgs 143-145	Network Management	Please clarify the target group and any service limitations for adult medical day care services.	Adult medical day care services are defined in NH Administrative rule He-E 800: http://www.gencourt.state.nh.us/rules/default.htm

Official Questions Answers for
RFP-2019-OMS-02-MANAG
Medicaid Care Management Services

ID	Reference	Category	Respondent Question	DHHS Response
068	Model Contract 4.7.3 Time and Distance Standards, pgs 143-146	Network Management	Please clarify the target group and any service limitations for hospice services.	Hospice services are defined in NH Administrative rule He-W 544: http://www.gencourt.state.nh.us/rules/default.htm
069	Model Contract 4.7.3 Time and Distance Standards and 4.7.3.4 , pgs 143-144	Network Management	The access standard for MLADCs in section 4.7.3 of the Model Contract provides 1 within 45 minutes or 15 miles and section 4.7.3.4 indicates no less than 2 Providers in any public health region unless there are less than 2 such providers in the region. Request clarification if both requirements are correct?	The access standards outlined in the two references represent two different sets of geographic regions. The standards in 4.7.3 are evaluated at the NH county level. The standards in 4.7.3.4 are evaluated at the public health region level.
070	Model Contract 4.7.3 Time and Distance Standards and 4.7.3.4 , pgs 144-145	Network Management	The access standard for Substance Use Disorder Programs in section 4.7.3 of the Model Contract provides 1 within 60 minutes or 45 miles and section 4.7.3.4 indicates no less than 2 Providers in any public health region unless there are less than 2 such providers in the region. Request clarification if both are correct?	The access standards outlined in the two references represent two different sets of geographic regions. The standards in 4.7.3 are evaluated at the NH county level. The standards in 4.7.3.4 are evaluated at the public health region level.
071	Model Contract Section 4.3.6, RFP section 2.3, Model Contract p.97, RFP pg.13	Enrollment	Will DHHS provide detailed historical auto assignment information including counts of members assigned based on: 1. preference to an MCO with which there is a family affiliation, 2. Previous MCO enrollment, 3. Provider-Member relationship, and 4. all other auto assignments?	The program structure implemented by DHHS to meet its commitment to providing new entrant(s) with the ability to achieve an equitable share of MCM Members within twelve (12) to eighteen (18) months of program (as described in Section 2.2.2.1 of the RFP and 5.2.1 of Appendix D) will vary based on the MCOs selected; DHHS anticipates working collaboratively with selected MCOs to meet this commitment and will provide further information when available.
072	RFP 2.2.1, pg 8	Enrollment	If Auto-Assignment as outlined in the RFP is not sufficient to "allow new entrant(s) the ability to achieve an equitable share of MCM Members within twelve (12) to eighteen (18) months of the beginning of the new contract" will DHHS entertain other mechanisms to increase membership to new entrants to achieve a scale necessary to operate?	The program structure implemented by DHHS to meet its commitment to providing new entrant(s) with the ability to achieve an equitable share of MCM Members within twelve (12) to eighteen (18) months of program (as described in Section 2.2.2.1 of the RFP and 5.2.1 of Appendix D) will vary based on the MCOs selected; DHHS anticipates working collaboratively with selected MCOs to meet this commitment and will provide further information when available.
073	Model Contract Section 5.1.3.21, pg 280	Rates and Payments	Is an 820 file currently being used for MCO payments? If not, what is being used as detail for payment reconciliation purposes and can an example be provided?	DHHS estimates an implementation date to coincide with the Program start, this will be reviewed as part of readiness.
074	RFP section 2.3 pg 10, Appendix E pg 4	Cost Component - RFP	Should care management costs be included in administrative costs for Question #126? Is it different for MCO delivered vs. local care management entity delivered services? Is payment for these services to the MCO included in the administrative load or as part of medical costs?	All estimated SFY 2020 MCO administrative costs should be included in Table F found in Appendix E-1 "RFP Cost Component Questions Excel Template", including care management services delegated to Local Care Management entities. Respondents should include a description of the treatment of Local Care Management entity costs in the narrative description requested in Part 3 of Question 126 in Appendix E. Note that case management services that are billed by qualifying providers as a service should be excluded from administrative costs.
075	RFP section 2.1.1.2, pg 7	Rates and Payments	Can the state provide any financial and/or utilization data associated with the new NH Health Protection Program (Expansion) population?	CY2016 and CY2017 Premium Assistance Program (PAP) Cost Models and SFY 2019 capitation rate reports for the Medically Frail and Transitional populations currently served under NHHPP are available as reference documents to the RFP on the Department website: https://www.dhhs.nh.gov/business/rfp/rfp-2019-oms-02-manag.htm
076	MCM Program SFY2019 Capitation Rates, pg 18	Rates and Payments	On page 18 of the SFY2019 Rate Development, it is indicated that Hospital Inpatient - Children's Specialty Services are funded below the MCO contract rates with providers. Does DHHS intend to increase funding for these services in the future or otherwise address this disconnect?	DHHS and its actuaries review reimbursement assumptions annually as part of the capitation rate development process.
077	Appendix E, pgs 2-4	Cost Component - RFP	Will current information on either utilization data, financial detail or description of current programs be made available in order to answer questions 111, 119, and 120 related to how MCOs will improve on current performance?	See Reference Documents to the RFP on the Department website: https://www.dhhs.nh.gov/business/rfp/rfp-2019-oms-02-manag.htm

Official Questions Answers for
RFP-2019-OMS-02-MANAG
Medicaid Care Management Services

ID	Reference	Category	Respondent Question	DHHS Response
078	Appendix E, pg 2	Pharmacy	For Question 112 can DHHS provide additional information on the changes to the Preferred Drug List under the new contract vs. the structure represented in the SFY2019 rate development.	DHHS' PDL is posted on the DHHS pharmacy website: https://www.dhhs.nh.gov/ombp/pharmacy/index.htm.
079	RFP 2.3, Draft MCM Withhold and Incentive Guidance, pg 15	Rates and Payments	Is it expected that 100% of withhold funds will be redistributed to MCOs as a whole via the Earned Withhold or the Incentive Payments?	As described in Section 3.3.3 of the MCM Withhold and Incentive Program Guidance, an MCO may earn less than, equal to, or more than the MCO's contribution to the Withhold, provided that no MCO's total revenue is greater than 105% of the MCO's qualifying capitation revenue in accordance with federal regulation. The amount of the Withhold redistributed will depend upon MCO performance.
080	RFP 2.3, Draft MCM Withhold and Incentive Guidance, pg 16	Rates and Payments	The draft guidance on the MCM withhold indicates a 2% withhold. Is this still the intended withhold amount?	As described in Section 3.1.1 of the MCM Withhold and Incentive Program Guidance, the total withhold amount to be recouped by DHHS is equal to two percent (2%) of the Capitation Rate for Medicaid-eligible enrollees in the MCM program, net of directed payments.
081	Respondent Conference	Rates and Payments	During the Respondent Conference on 9/7 it was indicated that DHHS is paying current plans 3 months in arears. Is this an accurate statement? Does DHHS intend to reduce the lag between coverage dates and payment dates?	See Appendix C – Medicaid Care Management Services Model Contract Section 6.2.9 which states, "DHHS will make a monthly payment to the MCO for each Member enrolled in the MCO's plan as DHHS currently structures its capitation payments. Specifically, the monthly capitation payments for standard Medicaid will be made retrospectively with a three (3) month plus five (5) business day lag (for example coverage for July 1, 2019 will be paid by the 5th business day in October, 2019). Capitation payments for all Granite Advantage Members will be made before the end of each month of coverage."
082	RFP 4.1.7, pg 28	Technical - RFP	Can DHHS please provide the expected agenda for the Oral Presentation as well as indicate any anticipated topics and/or required staff members expected to attend?	No.
083	Appendix C; Medicaid Care Management Services Model Contract - Section 3.15.3 On-Site Presence, pg 67	Care Management	Section 3.15.3 "On-Site Presence" within the Model Contract references a position, Prior Authorization Coordinator, which is required to be located within New Hampshire. This position is not referenced or discussed within section 3.15.1 "Key Personnel," 3.15.2 "Other MCO Required Staff," or anywhere else within the RFP or Model Contract. Can DHHS provide background information regarding the required education and responsibilities for this position similar to the other positions listed in the Staffing section of the Model Contract?	Refer to Addendum #1.
084	Appendix D; 1.2. Managed Care Experience and References - Q #9, pg 3	Technical - RFP	Appendix D; Section 1 has a 7 page limit. Question #9 in section 1.2. Managed Care Experience and References of Appendix D requires the respondent to provide the name, title, qualifications, and resume for each individual for Key Personnel currently on staff with the Respondent. For staff to be hired, the respondent is required to describe the hiring process and the qualifications for the position and include the job description associated with each to-be-hired employee. Can the respondent provide the required resumes/job descriptions in an attachment as the 7-page limit will make it difficult to provide all required information?	Yes, Respondents are permitted to append the requested resumes.
085	RFP	Technical - RFP	In order to be more environmentally friendly, will DHHS consider allowing respondents to provide electronic only files for any attachments larger than 20 pages? (examples include P&Ps, financials, etc.)	No.
086	RFP 5.1.2 Presentation of Submissions, 5.1.2.1. and 5.1.2.2, pg 30	Technical - RFP	Would DHHS include three-ring binders in the list of acceptable formats provided in 5.12.2 of the RFP and accept copies of the response to be provided in three-ring binders?	Yes.

Official Questions Answers for
RFP-2019-OMS-02-MANAG
Medicaid Care Management Services

ID	Reference	Category	Respondent Question	DHHS Response
087	5.1.2. Presentation of Submissions and 5.1.2.1. , 5.1.3. Technical and Cost Proposal and 5.1.3.1, pg 30	Technical - RFP	5.1.2.1 of the RFP states the Original copy of the Technical and Cost Components of the RFP shall be provided in separate three-ring binders. 5.1.3.1 states the original of the Technical Proposal and Cost Components of the RFP shall each be provided in a three-ring binder marked as "Original." Please clarify if the State wants the Technical Proposal and Cost Components of the RFP together in a single three-ring binder or provided in separate three-ring binders.	Refer to Addendum #1.
088	Model Contract Section 2.1 and Section 4.10.3, pgs 27 and 175	Care Management	Please confirm the definition of Priority Populations; “recently incarcerated” members are listed on page 175 of the Model Contract, however they are not listed on page 27 under the definition of Priority Population. What is the definition of Priority Populations?	Refer to Addendum #1.
089	Appendix D, Q #49, pgs 21-22	Technical - RFP	Please clarify the difference in risk scoring and stratification process, tools and methods between Q49 (2) (a) and 2(b), specifically how does the request for a description of risk scoring and stratification requested in (a) "the identification, Risk Scoring and Stratification process, tools and methods that the Respondent will use for identifying the Priority Populations" differ from the description of the risk scoring and stratification that is requested in (b) "A description of the plan and methodology for conducting Risk Scoring and Stratification"?	DHHS requires a description of the risk scoring and stratification process used to identify the priority population and a description of the risk scoring and stratification process for the general population if it is different from the methods used for the priority population.
090	Appendix D, Q #58(4) and 59, pgs 26-27	Population Health	Suicide prevention strategies are requested in question 58 (4) and again in question 59. If this is not a formatting error, please clarify how the two questions differ.	Question 58(4) refers to collaboration and coordinated effort with CMH Programs/ CMH Providers (or similar provider) concerning suicide prevention awareness and promotion of suicide prevention programs. Question 59 refers to the respondent’s strategies and actions conducted independently from CMH Programs/ CMH Providers that it will utilize to increase suicide prevention awareness and promote suicide prevention programs broadly in New Hampshire.
091	Appendix D, Question 67, pg 29	Technical - RFP	Question 67 on Health Homes was moved from the Behavioral Health section in the Draft RFP to Section 14 Children with Special Health Care Needs in the official RFP. However, the page limits for Children with Special Health Care Needs were not increased from the five allotted pages in the Draft RFP. Will DHHS consider increasing the page limit in Section 14 to accommodate the addition of the new question on Health Homes?	Refer to Addendum #1.
092	9/7/18 Mandatory Respondent Conference Handout, P. 10, 3rd Bullet, p. 10	Rates and Payments	This DHHS Handout states “The Department will develop actuarially sound capitation rates for the first year of the contract (July 1, 2019 – June 30, 2020) after MCO selection, MCO contract execution, and the Governor and Executive Council approval.” [Question:] (1) Based on this stated sequence of events, can DHHS confirm: (a) that it plans for selected MCOs to execute the MCO contract prior to DHHS release of capitation rates? If so, will bidders receive either preliminary rates or an actuarially sound rate range prior to contract execution in order to seek appropriate internal and Board approvals prior to contract execution?	Yes, DHHS plans to execute MCO contracts prior to DHHS releasing the capitation rate reports. The draft SFY 2020 capitation rates will be presented to the MCOs in Spring 2019. There are currently no plans to provide preliminary rates or rate range prior to contract execution.
093	9/7/18 Mandatory Respondent Conference Handout, P. 10, 3rd Bullet, p. 10	Rates and Payments	This DHHS Handout states “The Department will develop actuarially sound capitation rates for the first year of the contract (July 1, 2019 – June 30, 2020) after MCO selection, MCO contract execution, and the Governor and Executive Council approval.” [Question:] (1) Based on this stated sequence of events, can DHHS confirm: (b) whether the MCO contract will contain language that the MCOs’ contractual obligations will be contingent on agreement with the final capitation rates?	No.

Official Questions Answers for
RFP-2019-OMS-02-MANAG
Medicaid Care Management Services

ID	Reference	Category	Respondent Question	DHHS Response
094	9/7/18 Mandatory Respondent Conference Handout, P. 10, 3rd Bullet, p. 10	Rates and Payments	This DHHS Handout states "The Department will develop actuarially sound capitation rates for the first year of the contract (July 1, 2019 – June 30, 2020) after MCO selection, MCO contract execution, and the Governor and Executive Council approval." [Question:] (2) Can DHHS state when either/both the preliminary and/or final capitation rates will be made available?	DHHS will develop actuarially sound capitation rates for the first year of the contract (July 1, 2019 – June 30, 2020) after MCO selection, MCO contract execution, and the Governor and Executive Council approval. The draft SFY 2020 capitation rates will be presented to the MCOs in Spring 2019.
095	Appendix D, Mandatory Responses to Technical Components of RFP, Section 13. Behavioral Health, p. 27	Population Health	Q58. As indicated in the MCM Model Contract, MCOs will be required to enter into capitated payment arrangements with CMH Programs/CMH Providers,1,2 providing for reimbursement on terms specified by DHHS in forthcoming guidance. Describe the Respondent's ability to support capitated contract arrangements with community mental health centers and experience supporting these or similar arrangements in other states, including functions such as:4) Establishing a coordinated effort for Substance Use Disorder treatment in collaboration with CMH Programs/CMH Providers (or similar provider). Describe the Respondent's strategies and actions it will utilize to increase suicide prevention awareness and promote suicide prevention programs broadly in New Hampshire. [...] [Continued in next record]	Refer to the response at Line ID 96.
096	Appendix D, Mandatory Responses to Technical Components of RFP, Section 13. Behavioral Health, p. 27	Population Health	[Continued from previous record:] [...] Q59. Describe the Respondent's strategies and actions it will utilize to increase suicide prevention awareness and promote suicide prevention programs broadly in New Hampshire. Q58. 4 and Q59 both state: "Describe the Respondent's strategies and actions it will utilize to increase suicide prevention awareness and promote suicide prevention programs broadly in New Hampshire." [Question:] Is there an intended difference in these questions or should MCOs respond to just one?	Question 58(4) refers to collaboration and coordinated effort with CMH Programs/ CMH Providers (or similar provider) concerning suicide prevention awareness and promotion of suicide prevention programs. Question 59 refers to the respondent's strategies and actions conducted independently from CMH Programs/ CMH Providers that it will utilize to increase suicide prevention awareness and promote suicide prevention programs broadly in New Hampshire.
097	Appendix D, Mandatory Responses to Technical Components of RFP, Section 16. Network Management, p. 33	Network Management	Q75. Ongoing Provider support is important to ensuring Members' access to and the delivery of high-quality care. DHHS is committed to improving the Provider credentialing process and exploring opportunities to centralize Provider credentialing in the near future. Please describe the Respondent's proposed approach for:... [Question:] Can DHHS elaborate on plans to centralize provider credentialing?	The timeframe for Centralized Provider Credentialing has not been finalized. There are 4 phases: research of existing models, planning and design, contracting with outside vendors and implementation. A preliminary target date (subject to change) to finish the planning and design of Centralized Provider Credentialing is June 2020.
098	Appendix D, Mandatory Responses to Technical Components of RFP, Section 16. Network Management, p. 33	Network Management	Q75. Ongoing Provider support is important to ensuring Members' access to and the delivery of high-quality care. DHHS is committed to improving the Provider credentialing process and exploring opportunities to centralize Provider credentialing in the near future. Please describe the Respondent's proposed approach for:... [Question:]When does DHHS anticipate this program to go-live?	The timeframe for Centralized Provider Credentialing has not been finalized. There are 4 phases: research of existing models, planning and design, contracting with outside vendors and implementation. A preliminary target date (subject to change) to finish the planning and design of Centralized Provider Credentialing is June 2020.
099	Appendix D, Mandatory Responses to Technical Components of RFP, Section 2, Q10. 11), p. 6	Technical - RFP	Section 2 Subcontractors Q.10. 11) Signed letters of commitment from the Subcontractors, if applicable. [Question:] This question asks for signed LOCs "if applicable." There is no description in the RFP or Appendix D of when such LOCs would or would not be "applicable." Can you please confirm whether LOCs are required from all the Respondent's Subcontractors which are identified by the Respondent in its answer to Q.10. 1); or if not, when such LOCs would or would not be "applicable?"	The Respondent should provide to DHHS any letters of commitment that are available for Subcontracted services at this time. DHHS will provide additional information about its assessment of MCOs' Subcontractor agreements during the readiness review period.

Official Questions Answers for
RFP-2019-OMS-02-MANAG
Medicaid Care Management Services

ID	Reference	Category	Respondent Question	DHHS Response
100	Appendix E, Mandatory Responses to Cost Components of the RFP, Section 1, Q105., p. 1	Cost Component - RFP	1. Managed Care Savings Opportunities Q105. For each of the managed care strategies proposed by the Respondent in the answers to questions in sections 10 (Utilization Management), 12 (Care Coordination and Care Management) and 13 (Behavioral Health) of the Technical Proposal (Appendix E), quantify the estimated reduction in overall per member per month (PMPM) service cost resulting from successful implementation of the Respondent's care management strategies to reduce service utilization and/or move care to more cost-effective settings. [Question:] DHHS is requesting bidders to quantify the estimated reduction in PMPM service cost from successful implementation of care management strategies. Please advise at what level (e.g., rate cell or population) the PMPM estimates should be provided and clarify the time period for the estimated reductions.	Estimates should be provided in aggregate for each managed care strategy item described in Sections 10, 12, and 13, and reflect full implementation of the respondent's managed care strategy regardless of the time needed to fully implement. If available, comments related to the time needed to fully implement and any differences by population (MCM, Medically Frail, Granite Advantage) are welcome, but not necessary.
101	Appendix E, Mandatory Responses to Cost Components of the RFP, Section 1, Q105., p. 1	Cost Component - RFP	1. Managed Care Savings Opportunities Q105. For each of the managed care strategies proposed by the Respondent in the answers to questions in sections 10 (Utilization Management), 12 (Care Coordination and Care Management) and 13 (Behavioral Health) of the Technical Proposal (Appendix E), quantify the estimated reduction in overall per member per month (PMPM) service cost resulting from successful implementation of the Respondent's care management strategies to reduce service utilization and/or move care to more cost-effective settings. [Question:] DHHS is requesting bidders to quantify the estimated reduction in PMPM service cost from successful implementation of care management strategies. Please advise if a calculated PMPM savings is required or a savings percentage is sufficient.	Respondents should provide answers to Q105 on a PMPM basis.
102	Appendix E, Mandatory Responses to Cost Components of the RFP, Section 1, Q106.-Q110, pp. 1-2	Cost Component - RFP	Q106. With respect to the estimated cost reduction described in Q105 above, specifically focusing on emergency department (ED) visits, provide the following information:1) List and describe care management activities aimed at reducing emergency room visits. Include comments related to reducing utilization of non-emergent ED visits as well as programs that proactively prevent emergent ED visits.2) Describe components of those activities that have been driving positive results.3) Provide estimates of emergency room visits reduction percentages achieved through these activities in other states. Q107. With respect to the estimated cost reduction described in Q105 above, specifically focusing on avoidable hospital readmissions, provide the following information:1) List and describe care management activities aimed at reducing avoidable hospital readmissions. [...] [Continued in next record]	Refer to the response at Line ID 105.
103	Appendix E, Mandatory Responses to Cost Components of the RFP, Section 1, Q106.-Q110, pp. 1-2	Cost Component - RFP	[Continued from previous record:] [...] 2) Describe components of those activities that have been driving positive results.3) Provide estimates of hospital readmission rate reduction percentages achieved through these activities in other states. Q108. With respect to the estimated cost reduction described in Q105 above, specifically focusing on avoidable hospital admissions, provide the following information:1) List and describe care management activities aimed at reducing avoidable hospital admissions.2) Describe components of those activities that have been driving positive results.3) Provide estimates of hospital admission rate reduction percentages achieved through these activities in other states. [...] [Continued in next record]	Refer to the response at Line ID 105.

Official Questions Answers for
RFP-2019-OMS-02-MANAG
Medicaid Care Management Services

ID	Reference	Category	Respondent Question	DHHS Response
104	Appendix E, Mandatory Responses to Cost Components of the RFP, Section 1, Q106.-Q110, pp. 1-2	Cost Component - RFP	[Continued from previous record:] [...] Q109. With respect to the estimated cost reduction described in Q105 above, specifically focusing on substance use disorder/opioid addiction treatment, provide the following information:1) List and describe care management activities aimed at improving access and outcomes for substance use disorder/opioid treatment.2) Describe components of those activities that have been driving positive results.3) Provide estimated cost savings achieved through these activities in other states.4) Identify the types of services where savings can be attained vs. types of services that may increase due to improved access to SUD services. [...] [Continued in next record]	Refer to the response at Line ID 105.
105	Appendix E, Mandatory Responses to Cost Components of the RFP, Section 1, Q106.-Q110, pp. 1-2	Cost Component - RFP	[Continued from previous record:] Q110. With respect to the estimated cost reduction described in Q105 above, specifically focusing on the integrated management of physical and behavioral health services, provide the following information:1) List and describe care management activities aimed at improving access and outcomes for members with a behavioral health condition.2) Describe components of those activities that have been driving positive results.3) Provide estimated cost savings achieved through these activities in other states.4) Identify the types of services where savings can be attained vs. types of services that may increase [Question:] Please advise if DHHS is requesting information regarding planned care management activities for New Hampshire or programs already implemented in other states for parts 1 and 2 of each question. [...] [Continued in next record]	Respondents should structure their answers to Q106-Q110 as follows: 1) Planned care management activities for New Hampshire 2) For the activities listed in Part 1, respond based on current experience with Medicaid populations whether in New Hampshire, if available, or other states
106	Appendix E, Mandatory Responses to Cost Components of the RFP, Section 1, Q106.-Q110, pp. 1-2	Cost Component - RFP	[Continued from previous record:] Additionally, at what level (e.g., rate cell or population) should the realized savings for part 3 of each question be provided?	Responses to part 3 of Q106-Q110 should be provided in aggregate. If available, comments related to differences by population (MCM, Medically Frail, Granite Advantage) are welcome, but not necessary.
107	Appendix E, Mandatory Responses to Cost Components of the RFP, Section 1, Q111, p. 2	Cost Component - RFP	Q111. Based on the Respondent's review of the SFY 2019 MCM program and NHHPP capitation rate reports, what areas appear to offer the greatest potential for successful care management activities and overall cost savings? [Question:] DHHS is requesting bidders to provide areas that offer the greatest potential for successful care management activities. Please advise if DHHS is quantifying the greatest areas on a percentage or PMPM basis and if a quantification of those savings needs to be provided in response to this question.	Responses to Q111 do not require quantification of expected savings for areas with the greatest potential for savings. If available, quantification of those areas are welcome, but not necessary.
108	Appendix E, Mandatory Responses to Cost Components of the RFP, Section 3, Q124 & 125, p. 4	Cost Component - RFP	3. Program Integrity – Fraud, Waste, and Abuse Q124. Consistent with the responses in Section 20 of the Technical Proposal (Appendix E), quantify the identification and recovery of provider overpayments in managed care programs in other states due to fraud, waste, and abuse using Table D.Q125. Provide the requested information related to Provider recoveries related to suspected provider fraud or abuse in Table E for each state where the Respondent currently operates a Medicaid managed care program. [Question:] Can DHHS confirm that the data to be entered for Table D and Table E is for calendar year 2017? (With one exception there are no instructions in either Table regarding time frames for the data.)	Respondents should provide answers to Q124 based on the most recent available data and note the reported time period.

Official Questions Answers for
RFP-2019-OMS-02-MANAG
Medicaid Care Management Services

ID	Reference	Category	Respondent Question	DHHS Response
109	Appendix C, MCM Model Contract, 3.15.1.2.3 ; 3.15.3.1.11, pp. 63, 67	Staffing	3.15.1.2 Coordinators shall be responsible for overseeing Care Coordination and Care Management activities for MCO Members with complex medical, behavioral health, DD, and long term care needs; or for overseeing other activities. They shall also serve as liaisons to DHHS staff for their respective functional areas. The MCO shall assign coordinators to each of the following areas on a full-time basis:3.15.1.2.3 Mental Health Coordinator: Individual shall oversee the delivery of Mental Health Services to ensure that there is a single point of oversight and accountability. Individual shall have a minimum of a Master's Degree from a recognized college or university with major study in Social Work, Psychology, Education, Public Health or a related field. Individual shall have a minimum of eight (8) years demonstrated experience both in the provision of direct care services as well as progressively increasing levels of management responsibilities, [...] [Continued in next record]	Refer to the response at Line ID 110.
110	Appendix C, MCM Model Contract, 3.15.1.2.3 ; 3.15.3.1.11, pp. 63, 67	Staffing	[Continued from previous record:] [...] with a particular focus on direct care and administrative responsibilities within Community Mental Health Services. Other key functions shall include coordinating Mental Health Services across all functional areas including: quality management; oversight of the behavioral health Subcontract, as applicable; Care Management; Utilization Management; network development and management; Provider relations; implementation and interpretation of clinical policies and procedures; and social determinants of health and community based resources. [Question:] Model Contract Section 3.15.1.2.3 refers to a Mental Health Coordinator (page 63) and a Model Contract Section 3.15.3.1.11 Behavioral Health Coordinator (page 67). Can DHHS confirm that the positions are the same and also confirm which title bidders should use in their responses?	Refer to Addendum #1.
111	Appendix C, MCM Model Contract, 3.15.3.1.18 ;3.15.3.1.7, pp. 66-67	Staffing	3.15.3 On-Site Presence 3.15.3.1 The MCO shall have an on-site presence in NH. On-site presence for the purposes of this Section 3.15.3 of the Agreement means that the MCO's personnel resides or reports to work every day in the State of New Hampshire. Without exception, the following personnel shall be located in NH:3.15.3.1.18 Prior Authorization Coordinator and related personnel. [Question:] Can DHHS further clarify the scope of the role of the Prior Authorization Coordinator as referenced in section 3.15.3.1.18?	Refer to Addendum #1.
112	Appendix C, MCM Model Contract, 3.15.3.1.18 ;3.15.3.1.7, pp. 66-67	Staffing	3.15.3 On-Site Presence3.15.3.1 The MCO shall have an on-site presence in NH. On-site presence for the purposes of this Section 3.15.3 of the Agreement means that the MCO's personnel resides or reports to work every day in the State of New Hampshire. Without exception, the following personnel shall be located in NH:3.15.3.1.18 Prior Authorization Coordinator and related personnel. [Question:] Can DHHS further clarify what MCO personnel would qualify as "related personnel" as referenced in section 3.15.3.1.18?	Refer to Addendum #1.

Official Questions Answers for
RFP-2019-OMS-02-MANAG
Medicaid Care Management Services

ID	Reference	Category	Respondent Question	DHHS Response
113	Appendix C, MCM Model Contract, 3.15.3.1.18 ;3.15.3.1.7, pp. 66-67	Staffing	3.15.3 On-Site Presence 3.15.3.1 The MCO shall have an on-site presence in NH. On-site presence for the purposes of this Section 3.15.3 of the Agreement means that the MCO's personnel resides or reports to work every day in the State of New Hampshire. Without exception, the following personnel shall be located in NH:3.15.3.1.18 Prior Authorization Coordinator and related personnel. [Question:] Can DHHS confirm that Prior Authorization would only apply to the initial review for service and not any subsequent concurrent reviews or retrospective reviews of service?	Refer to Addendum #1.
114	Appendix C, MCM Model Contract, 3.15.3.1.18 ;3.15.3.1.7, pp. 66-67	Staffing	3.15.3 On-Site Presence 3.15.3.1 The MCO shall have an on-site presence in NH. On-site presence for the purposes of this Section 3.15.3 of the Agreement means that the MCO's personnel resides or reports to work every day in the State of New Hampshire. Without exception, the following personnel shall be located in NH:3.15.3.1.18 Prior Authorization Coordinator and related personnel. [Question:] If MCO staff participating in Prior Authorization activities qualify as "related personnel", do the requirements of this section apply to subcontractors of the MCO to which certain Prior Authorization functions may be delegated?	Refer to Addendum #1.
115	Appendix C, Model Contract, 4.1.2, Covered Services Grid, pp. 70-74	Covered Services	The current MCM contract indicates that chiropractic is a service for NHHPP. The draft Model Contract does not contemplate a chiropractic benefit, even for Granite Advantage Program members who will participate in MCM when the new contract commences. Is DHHS planning to eliminate this benefit and if so, when?	New Hampshire Medicaid Fee-for-Service is eliminating the chiropractic benefit for the NHHPP population, effective end of day-December 31, 2018.
116	Appendix C, Model Contract, 4.1.2, Covered Services Grid, p. 74	Covered Services	Please provide information on the Transitional Housing Program Services and Community Residential Services benefit.	Transitional housing and community residences provide room and board with wrap-around support and rehabilitation services to the adults within their care. The program serves the clinical, medical, vocational, and residential needs of adult men and women with mental illness. Services include: psychiatric services, medication management, clinical services, medical services, residential, targeted case management, specialized and co-occurring treatment services, vocational and day treatment services, support for community connectedness and family involvement, open community with families and individuals, a comprehensive approach to service delivery driven by participant involvement, and evidence based practice approaches that include Illness Management and Recovery.
117	Appendix C, Model Contract, 4.1.2, Covered Services Grid, p. 74	Covered Services	Who can receive these [Transitional Housing Program Services and Community Residential Services] benefits?	Adults who meet criteria for severe mental illness or severe and persistent illness and are eligible for community mental health services and no longer meet the level of care provided by New Hampshire Hospital or Designated Receiving Facilities.
118	Appendix C, Model Contract, 4.1.2, Covered Services Grid, p. 74	Covered Services	How many people presently participate [in Transitional Housing Program Services and Community Residential Services]?	At this time, New Hampshire provides 67 Transitional Housing Beds. This number will increase in future years. There are approximately 200 Community Residential beds.
119	Appendix C, Model Contract, 4.1.2, Covered Services Grid, p. 74	Covered Services	What is the current source and rate of reimbursement and payment methodology [for Transitional Housing Program Services and Community Residential Services]?	Transitional Housing Program Services are a Community Mental Health service currently reimbursed through NH Medicaid at fee for service rates for Medicaid eligible members. Community Residences bill services through the Medicaid service array.

Official Questions Answers for
RFP-2019-OMS-02-MANAG
Medicaid Care Management Services

ID	Reference	Category	Respondent Question	DHHS Response
120	Appendix C, Model Contract, 4.2.2.1, p. 85	Pharmacy	4.2.2 MCO Formulary 4.2.2.1 The PDL is established by DHHS. The MCO shall develop a formulary that adheres to DHHS's PDL for drug classes included in the PDL and is consistent with Section 4.2.1 (MCO and DHHS Covered Prescription Drugs). In the event that DHHS makes changes to the PDL,DHHS shall notify the MCO of the change and provide the MCO with 30 calendar days to implement the change. [Question:] If DHHS will provide 30 day notice of PDL changes to the MCO, will the MCO be required to provide 30 day notice of these PDL changes to members and providers? If so, please consider a longer notice period to the MCOs to enable the MCOs to give 30-day notice to members and providers.	DHHS will provide 60 days' notice to the MCOs to allow for the time needed for coding changes and the 30 day notification to members and providers.
121	Appendix C, Model Contract, 4.7.3.4, pp. 144-145	Network Management	Will DHHS share the full list of all MLDAC, OTP, Buprenorphine, Residential Substance Use Disorder Treatment Programs and Peer Recovery Programs licensed and practicing in New Hampshire?	For all licensed individuals and facilities within the state, please go to: https://nhlicenses.nh.gov/verification/Search.aspx?facility=N. Another helpful resource is: https://www.oplc.nh.gov/alcohol-other-drug/. Buprenorphine information is best collected from SAMHSA.
122	Appendix C, Model Contract, 4.8.1.6.10, p. 162	Utilization Management	4.8.1.6.10 Upon receipt of Prior Authorization information from DHHS, the new MCO shall honor Prior Authorizations in place by the former MCO as described in Section 4.7.9. (Access to Providers During Transitions of Care). The new MCO shall review the service authorization in accordance with the urgent determination requirements of Section 4.8.4.1 (Urgent Determinations and Covered/Extended Services). [Question:] Can you tell us by what means, and in what timeframe, DHHS will provide the new MCO with open PA information that DHHS receives from the previous MCO?	The MMIS will generate a nightly (Monday-Friday) prior authorization interface. The exact schedule will be determined through implementation but DHHS anticipates that the prior authorization interface will begin with the start of member open enrollment. As members select their new MCOs during open enrollment, the PA interface will be generated and include all PAs that span the start date of the new MCO.
123	Appendix C, Model Contract, 4.10.2., p. 175	Care Management	4.10.2.2 The MCO shall conduct a Health Risk Assessment Screening of all existing and newly enrolled Members within ninety (90) days of the effective date of MCO enrollment to identify Members who may have unmet health care needs and/or Special Health Care Needs [42 CFR 438.208(c)(1)]. [Question:] For members receiving care management, can the annual comprehensive assessment be considered as the Health Risk Assessment Screening?	Yes, for members receiving care management, the annual comprehensive assessment may be considered as the HRAs.
124	Appendix C, Model Contract, 4.10.5.1, p. 177	Care Management	4.10.5 Comprehensive Assessment for High-Risk and High-Need Members 4.10.5.1 The MCO and its Subcontractors shall implement mechanisms to conduct a Comprehensive Assessment for each Medicaid Member in order to identify whether they have Special Health Care Needs and any on-going special conditions that require a course of treatment or regular care monitoring. [42 CFR 438.210(b)(1) [Question:] Can DHHS clarify what is meant by "a course of treatment"?	A course of treatment is management of a defined health condition. A course of treatment, for example, could include radiation therapy for cancer or ECT treatment for a mental health condition.
125	Appendix C, Model Contract, 4.10.8.6.1, p. 184	Care Management	4.10.8.6. Designated Local Care Management Entities shall include: 4.10.8.6.1. IDNs that have been certified as Local Care Management Entities by DHHS. [Question:] DHHS states that the MCO must contract with Local Care Management Entities to provide Care Management services. Will IDNs be permitted to provide Care Management Services without DHHS designating them as Designated Local Care Management Entity?	IDNs will not be permitted to provide care management services without DHHS designation as a local care management entity.

ID	Reference	Category	Respondent Question	DHHS Response
126	Appendix C, Model Contract, 2.1.100.1, p. 28	Psychiatric Boarding	2.1.100 Psychiatric Boarding 2.1.100.1 “Psychiatric Boarding” means a Member’s continued physical presence in an emergency room or another temporary location after either completion of an Involuntary Emergency Admission (IEA) application, revocation of a conditional discharge, or commitment to New Hampshire Hospital or other designated receiving facility by a Court. [Question:] Can DHHS state what period of time beyond completion of an IEA, revocation of conditional discharge, or commitment to New Hampshire Hospital or other designated receiving facility constitutes psychiatric boarding?	Boarding begins immediately upon completion of the identified qualifying event. Children are also constituted as boarding while awaiting a bed via a voluntary placement.
127	Appendix C, Model Contract, 2.1.100.1, p. 28	Psychiatric Boarding	2.1.100 Psychiatric Boarding 2.1.100.1 “Psychiatric Boarding” means a Member’s continued physical presence in an emergency room or another temporary location after either completion of an Involuntary Emergency Admission (IEA) application, revocation of a conditional discharge, or commitment to New Hampshire Hospital or other designated receiving facility by a Court. [Question, see previous question for context:] Will this timing take into consideration delays in placement in order to coordinate transportation and other logistics that are beyond the MCO's control?	No.
128	Appendix C, Model Contract, 4.11.5.17.1;3.15.2.2- 3.15.2.4, pp. 210-211	Psychiatric Boarding	4.11.5.17 Reducing Psychiatric Boarding 4.11.5.17.1 For each hospital in its network, the MCO must have on its own staff or contract with clinical Providers who are credentialed by the hospital (i.e., “hospital-credentialed Providers”) to provide services to reduce Psychiatric Boarding stays. In meeting this requirement, the MCO cannot use CMH Programs and CMH Providers and must ensure that its hospital-credentialed Providers are in addition to any capacity provided by CMH Programs and CMH Providers. The MCO must supply a sufficient number of hospital-credentialed Providers in order to provide assessments and treatment for Members who are subject to or at risk for Psychiatric Boarding. The number of such hospital credentialed Providers must be sufficient to provide initial on-site assistance within twelve (12) hours of a Member arriving at an ED and within twenty-four (24) hours of a Member being placed on observation or inpatient status to await an inpatient psychiatric bed. [...] [Continued in next record]	Refer to the response at Line ID 129.
129	Appendix C, Model Contract, 4.11.5.17.1;3.15.2.2- 3.15.2.4, pp. 210-211	Psychiatric Boarding	[Continued from previous record:] [...] The initial on-site assistance provided within these required timelines must include a beneficiary-specific plan for discharge, treatment, admittance or transfer to New Hampshire Hospital. Each such hospital-credentialed Provider must have the clinical expertise to reduce Psychiatric Boarding and possess or be trained on the resources, including local community resources that can be deployed to discharge the Member safely to the community or to a step down facility when an inpatient stay is not clinically required. At the request of DHHS, the MCO shall participate in meetings with hospitals to address Psychiatric Boarding. [Question:] Given the limited Behavioral Health resources in New Hampshire, specifically psychiatric, how will DHHS define what constitutes a “sufficient number of hospital credentialed Providers” and then measure and monitor that provider sufficiency? [Continued in next record]	The specified response time is the standard and measure of compliance In this instance. The MCO will be required to monitor and report compliance with this standard.
130	Appendix C, Model Contract, 4.11.5.17.1;3.15.2.2- 3.15.2.4, pp. 210-211	Psychiatric Boarding	[Continued from previous record:] Can DHHS provide a definition of “at risk for” Psychiatric Boarding?	Individuals presenting in a hospital emergency department in need of psychiatric and/or behavioral health services.

Official Questions Answers for
RFP-2019-OMS-02-MANAG
Medicaid Care Management Services

ID	Reference	Category	Respondent Question	DHHS Response
131	Appendix C, Model Contract, 4.11.5.17.1;3.15.2.2- 3.15.2.4, pp. 210-211	Psychiatric Boarding	[Continued from previous record:] Do "hospital-credentialed Providers" include non-MD providers, i.e. Psychiatric RNs, APRNs, and Licensed Behavioral Health Clinicians?	Yes.
132	Appendix C, Model Contract, 4.11.5.17.1;3.15.2.2- 3.15.2.4, pp. 210-212	Psychiatric Boarding	[Continued from previous record:] Q1 - Will DHHS provide a mechanism for MCOs to learn that a member has presented in the ED in real time so that MCO clinical response can be rendered within 12 hours of member presentation? Q2 - Will the 12 hour window for on-site assistance apply 24/7?	Q1 - the MCO is expected to implement that solution through contract with the Hospital. Q2 - Yes.
133	Appendix C, Model Contract, 4.11.5.17.1;3.15.2.2- 3.15.2.4, pp. 210-211	Psychiatric Boarding	[Continued from previous record:] Will the 12 hour window for on-site assistance apply 24/7?	Yes.
134	Appendix C, Model Contract, 4.11.5.17.2, p. 211	Psychiatric Boarding	4.11.5.17 Reducing Psychiatric Boarding 4.11.5.17.2 For any day during which the Member is subject to Psychiatric Boarding, the MCO shall pay to the New Hampshire Hospital's administrative day rate inclusive of both the State and federal share of the payment, and pay all other hospitals at no less than the rate paid by the NH Medicaid FFS program for all inpatient and outpatient services categories. [Question:] Can DHHS clarify the underlined language? That language seems to state that the MCO must pay to New Hampshire Hospital an administrative day rate for members who are boarding in other hospitals?	The language refers to an administrative day rate at NH Hospital for NH Hospital boarding. Additionally, MCOs are to further pay other hospitals no less than the Medicaid Fee Schedule for services during a boarding.
135	Appendix C, Model Contract, Exhibit N- Liquidated Damages Matrix - 1.16, p. 335 of Appendix C (pg. 2 of Exhibit N)	Psychiatric Boarding	Can DHHS explain what factors it will use to assess compliance with minimizing psych boarding requirements for purposes of assessing $5000 per day damages? Will DHHS take into consideration factors that are entirely beyond the control of the MCO in the psych boarding process (e.g. coordination of transportation)?	The Appendix C represents DHHS' expectation for MCO performance. Exhibit N accurately reflects the range of liquidated damages.
136	Appendix C, Model Contract, 4.11.6.15.4, p. 221	Utilization Management	4.11.6.15 Limitations on Prior Authorization Requirements 4.11.6.15.4 The MCO must cover without Prior Authorization or other Utilization Management restrictions any treatments identified as necessary by a clinician trained in the use and application of the ASAM Criteria. Should the MCO have concerns about the appropriateness of a course of treatment after the treatment has commenced, the MCO shall contact the Provider to request additional information and/or recommend a change, but must continue to pay for the treatment unless and until the Provider determines an alternative type of treatment or setting is appropriate. DHHS will monitor utilization of Substance Use Disorder treatment services identify, prevent, and correct potential occurrences of fraud, waste and abuse, in accordance with 42 CFR 455 and 42 CFR 456 and He-W 520. [...] [Continued in next record]	Refer to the response at Line ID 137.
137	Appendix C, Model Contract, 4.11.6.15.4, p. 221	Utilization Management	[Continued from previous record:] [...] DHHS will grant exceptions to this provision in instances where it is necessary to prevent fraud, waste and abuse. [Questions:] Does the restriction on PA prohibit an MCO from having a preferred MAT drug? If yes, how will the cost impact of covering all available MAT drugs without restriction be factored into the capitation rates?	The MCOs will be following the DHHS developed PDL. That information will be used to calculate the capitation rates.
138	Appendix C, Model Contract, 4.13.3.8, p. 237	Network Management	4.13.3 Provider Screening, Credentialing and Re-Credentialing 4.13.3.8 A "clean and complete application" is a claim that is signed and appropriately dated by the Provider. [Question:] Is the word "claim" intentional here, or is that word supposed to be "application"?	Refer to Addendum #1.

Official Questions Answers for
RFP-2019-OMS-02-MANAG
Medicaid Care Management Services

ID	Reference	Category	Respondent Question	DHHS Response
139	Appendix C, Model Contract, 4.14.4, p. 248	APM	4.14.4 Required Use of Alternative Payment Models Consistent with the New Hampshire Building Capacity for Transformation Waiver 4.14.4.1 Consistent with the requirements set forth in the special terms and conditions of NH's Building Capacity for Transformation waiver, the MCO shall ensure through its APM Implementation Plan (as described in Section 4.14) that fifty percent (50%) of all MCO medical expenditures are in Qualifying APMs, as defined by DHHS, within the first twelve (12) months of this Agreement, subject to the following exceptions: 4.14.4.1.1 If the MCO is newly participating in the MCM program as of the Program Start Date, the MCO shall have eighteen (18) months to meet this requirement; and [...] [Continued in next record]	Refer to the response at Line ID 141.
140	Appendix C, Model Contract, 4.14.4, p. 248	APM	[Continued from previous record:] [...] 4.14.4.1.2 If the MCO determines that circumstances materially inhibit its ability to meet the APM implementation requirement, the MCO shall detail to DHHS in its proposed APM Implementation Plan an extension request: the reasons for its inability to meet the requirements of this section and any additional information required by DHHS. If approved by DHHS, the MCO may use its alternative approach, but only for the period of time requested and approved by DHHS, which is not to exceed an additional six (6)months after the 18 months and potential extension. For failure to meet this requirement, DHHS reserves to right to issue remedies as described in Section 5.5.2 (Liquidated Damages) and Exhibit N, Section 3.2 (Liquidated Damages Matrix). [Question:] Can DHHS please clarify how 50% of medical expenditures is defined/will be calculated? [Continued in next record]	Refer to the response at Line ID 141.
141	Appendix C, Model Contract, 4.14.4, p. 248	APM	[Continued from previous record:] [Question:] Can DHHS please clarify the definition of 'medical expenditures'?	50% of direct medical expenditures payments to providers as defined under CMS MLR calculation regulations.
142	Appendix C, Model Contract, 4.14.4, p. 248	APM	[Continued from previous record:] [Question:] Is 'medical expenditures' the same as total cost of care?	Refer to the response at Line ID 141.
143	Appendix C, Model Contract, 4.14.6.3, p. 251	APM	4.14.6.3 Provider Engagement and Support 4.14.6.3.1 The APM Implementation Plan shall describe a logical and reasonably achievable approach to implementing APMs, supported by an understanding of NH Medicaid Providers' readiness for participation in APMs, and the strategies the MCO will use to assess and advance such readiness over time. The APM Implementation Plan shall outline in detail what strategies the MCO plans to use, such as, meetings with Providers and IDNs, as appropriate, and the frequency of such meetings, the provision of technical support, and a data sharing strategy for Providers reflecting the transparency, reporting and data sharing obligations herein and in the DHHS Medicaid APM Strategy. [Continued in next record]	Refer to the response at Line ID 144.

Official Questions Answers for
RFP-2019-OMS-02-MANAG
Medicaid Care Management Services

ID	Reference	Category	Respondent Question	DHHS Response
144	Appendix C, Model Contract, 4.14.6.3, p. 251	APM	[Continued from previous record:] [...] The MCO APM Implementation Plan shall ensure Providers and IDNs, as appropriate, are supported by data sharing and performance analytic feedback systems and tools that make actuarially sound and actionable provider level and system level clinical, cost, and performance data available to Providers in a timely manner for purposes of developing APMs and analyzing performance and payments pursuant to APMs.MCO shall provide the financial support for the Provider infrastructure necessary to develop and implement APM arrangements that increase in sophistication over time. [Question:] Will DHHS provide funding to the MCOs to support the significant infrastructure building that is required to "develop and implement APM arrangements that increase in sophistication over time" as noted in this section?	No. Improved administrative economy and medical expenditure efficiency through rationalizing care management is an actuarial value to be realized by the MCO.
145	Appendix C, Model Contract, 5.1.4., pp. 283-284	Technical - Contract	5.1.4.1 All data submitted to DHHS by the MCO shall be certified by one (1) of the following:5.1.4.1.1 The MCO's CEO;5.1.4.1.2 The MCO's CEO; or5.1.4.1.3 An individual who has delegated authority to sign for, and who reports directly to, the MCO's CEO or CFO. [42 CFR 438.604; 42 CFR 438.606(a)] [Question:] The CEO is listed twice - in both 5.1.4.1.1 and 5.1.4.1.2. Did DHHS intend to identify another position?	Refer to Addendum #1.
146	Appendix C, Model Contract, 6.3.3, pp. 315-316	MLR	6.3.3 Medical Loss Ratio Reporting 6.3.3.1 The MCO shall submit MLR summary reports quarterly to DHHS in accordance with Exhibit O [42 CFR 438.8(k)(2); 42 CFR 438.8(k)(1)]. The MLR summary reports shall include all information required by 42 CFR 438.8(k) within nine (9) months of the end of the MLR reporting year, including:... [Question:] For Medical Loss Ratio (MLR) reporting, is the measurement period the contract period or the calendar year?	The MLR.01 report is calculated on a quarterly basis. The report is due nine months after the end of the quarter.
147	Appendix C, MCM Model Contract, 6.11.8.2.3, p. 323	Third-Party Liability	6.11 Third Party Liability 6.11.8 Post Payment Recovery 6.11.8.2 Pay and Chase Private Insurance 6.11.8.2.3 The MCO shall have eight (8) months from last date of service to recover funds from private insurance. If funds have not been recovered by that date, DHHS has the sole and exclusive right to pursue, collect, and retain funds from private insurance. [Question:] Based on our understanding that an 8 month recovery standard is well below industry standards, is there potential for further consideration of the time frame for recovery indicated in the above section? Providers routinely have 3 months to submit claims to MCOs, so 8 months from the date of service to recover payments under TPL is very limiting. We propose a minimum of 12 months from the date of payment to recoup such funds.	For other states which include TPL populations in managed care and allow MCOs to engage in any recovery, four to six months from payment date is standard. An eight month timeframe from date of service with three months of allowed claims submissions allows MCOs an additional 5 months to bill insurance carriers and recover.
148	Appendix C, 4.6.11, pg 136	Appeals	Can and will DHHS make data available regarding Providers' access to the State's fair hearing system, including data on volume of requests and types of issues disputed by Providers through the fair hearing system?	No data will be shared on providers seeking recourse through the state fair hearing system. Providers must first exhaust the MCO's Provider Appeals Process prior to seeking recourse through the state's fair hearing system.
149	Appendix C, 4.6.11, pg 136	Appeals	Could you please provide the definition of "Provider Adverse Action", as referenced in Section 4.6.1.1 of the Model Contract?	Provider Adverse Actions are described in Section 4.6.2.1.
150	Appendix C, 4.7.2.1, pg 141	Network Management	What is the network adequacy percentage?	MCOs must meet 90% of the time or distance standards for a provider type in each county.

Official Questions Answers for
RFP-2019-OMS-02-MANAG
Medicaid Care Management Services

ID	Reference	Category	Respondent Question	DHHS Response
151	Appendix C, 4.7.2.1, pg 141	Network Management	There is no mention if there are differences in rural and urban counties, so are these the time and distance for the entire state?	Time and distance standards are statewide at this time.
152	Appendix C, 4.7.2.1, pg 141	Network Management	Does "Adult and Pediatric" for PCPs and mental health providers mean we combine them together or does this requirement say to map adults provider and pediatric providers separately based on their respective populations?	The Model Contract lists the network adequacy standard categories, but not all of the specific providers in each standard category. MCOs will need to report on the adequacy of individual provider types. Specific provider types will be included on the reporting template that will be provided to the MCOs during readiness review and for ongoing performance reporting.
153	Appendix C, 4.7.2.1, pg 141	Network Management	Q1 - What adult specialists are included in these categories? Q2 - Is each adult specialty supposed to meet the time and distance standards?	Specific provider types will be included on the reporting template that will be provided to the MCOs during readiness review and for ongoing performance reporting.
154	Appendix C, 4.7.2.1, pg 141	Network Management	Q1 - What pediatric specialists are included in these categories? Q2 - Is each pediatric specialty supposed to meet the time and distance standards?	Specific provider types will be included on the reporting template that will be provided to the MCOs during readiness review and for ongoing performance reporting.
155	Appendix C, 4.7.2.1, pg 141	Network Management	What resource can the MCO access to help it determine what services to include as “Tertiary or Specialized Services”?	The Model Contract lists the network adequacy standard categories (such as Tertiary), but not all the specific providers in each standard category. MCOs will need to report on the adequacy of individual provider types. Specific provider types will be included on the reporting template that will be provided to the MCOs during readiness review and for ongoing performance reporting.
156	Appendix C, 4.7.2.1 pg 141	Network Management	Can OBGYN Physicians (MD/DO), OBGYN Nurse Practitioners, and Certified Nurse Midwives be included as OBGYN providers (not “specialists” as written for adult and pediatric)?	Primary care provider is defined by the MCO and can include OBGYN providers. OBGYN providers must be reported separately as a specialist.
157	Appendix C, 4.7.2.1 pg 141	Network Management	Q1 - Will DHHS require the respondent to follow a template in its presentation of network adequacy numbers? Q2 - If so, when will DHHS make that template available?	Yes, the reporting template will be provided to the MCOs during readiness review and for ongoing performance reporting.
158	Appendix C, 4.7.2.1 pg 141	Network Management	Will GeoAccess maps (thermal or non-thermal) be required for submission?	No.
159	Appendix C, 4.7.2.1 pg 142	Network Management	What is the effect of network adequacy requirements promulgated by the New Hampshire Insurance Department (including NH RSA. 420-J and Admin Rule 2700), especially to the extent that such requirements may conflict with DHHS network adequacy requirements?	MCOs shall fully comply with all applicable laws and rules. MCOs shall fully comply with all DHHS network adequacy requirements in order to ensure compliance with governing CMS Medicaid Managed Care rules. In the event that NHID 2700 (effective 8/1/18) gives rise to significant additional reporting obligation(s) by the MCOs, DHHS may consult with NHID to identify possible future solutions that will not adversely impact full compliance with DHHS network adequacy requirements by the MCOs.
160	Appendix C, 4.7.2.5, pg 143	Network Management	Where can the “NH MCM Fifty Percent (50%) Population Estimate by Zip Code” report be found?	NH MCM Fifty Percent (50%) Population Estimate by Zip Code is available as a reference document to the RFP on the Department website: https://www.dhhs.nh.gov/business/rfp/rfp-2019-oms-02-manag.htm
161	Appendix C, 4.10.9.6.3, pg 188	Care Management	Do hospitals in New Hampshire today provide copies of the discharge plan/summary prior to the day of discharge?	MCOs would need to work with the hospitals to obtain copies of the discharge plans prior to the day of discharge.
162	Appendix C, 4.10.9.6.3, pg 188	Care Management	Will the State consider changing the length of time the MCO has to obtaining the discharge plan/summary?	No.
163	Appendix C, 4.11.5.15.1, pg 210	Behavioral Health	When will NH’s 10-Year Mental Health Plan be updated?	The new 10 year Mental Health Plan is under development. The draft plan will be available for public comment on or around 10/15/18 and will be open for written public comment for three weeks after its posting. The final draft will be available in Mid-November.

Official Questions Answers for
RFP-2019-OMS-02-MANAG
Medicaid Care Management Services

ID	Reference	Category	Respondent Question	DHHS Response
164	Appendix C, 4.11.5.17.1; 4.11.5.18.1.3, pg 210	Behavioral Health	In regards to Sections 4.11.5.17.1 and 4.11.5.18.1.3 of the Model Contract, currently, CMH Providers are held to certain standards to follow-up with members for psychiatric boarding/admissions. Will the state please clarify the difference and describe the roles of the MCO hospital-credentialed provider and the CMH Provider?	The MCOs are expected to fulfill the provisions as stated in the Model Contract.
165	Appendix C, 4.11.5.17, pgs 210-211	Behavioral Health	Will a telemedicine visit satisfy the contract requirement for "initial on-site assistance"?	Not at this time.
166	Appendix C, 4.14.2; 4.14.6.1, pg 247	APM	Q1 - Does the State anticipate releasing the "DHHS Medicaid APM Strategy" before October 30, 2018? Q2 - If not, Is there any guidance or other clarifying materials that DHHS can provide at this time?	Q1 - No. Q2 - No further guidance beyond the RFP and Appendices C, D and E. Refer to Addendum #1.
167	Appendix C, 4.14.6.3, pg 251	APM	Section 4.14.6.3 of the Model Contract states "MCO shall provide the financial support for the Provider infrastructure necessary to develop and implement APM arrangements that increase in sophistication over time; could you please provide clarification on what type and level of financial support is required?	That the MCO will make investments with an ROI for improved administrative economy and medical expenditure efficiency through rationalizing care management to ultimately achieve an actuarial ROI value to be realized by the MCO.
168	Appendix C, 4.15.1.4, pg 257	Technical - Contract	Will the state please provide a link to a complete and current version of the New Hampshire State Plan for our reference, including all related attachments?	The State Plan is not available online.
169	Appendix C, 5.3.1.6.1, pg 286	Program Integrity	Is the monthly allegation log the same document referred to as the FWA Log in Exhibit O FWA.02?	Yes, these are the same.
170	Appendix C, 5.3.3.7, pg 291	Program Integrity	Q1 - When will the metrics be distributed to MCOs? Q2 - Will the metrics be distributed in advance of the review period? Q3 - Will all MCOs be held accountable for the same metric numbers?	The metrics are in Appendix C Exhibit N. Program Integrity includes # 2.6, 2.7, 2.11, 2.13, and 4.3. The MCOs will be held accountable to the same metric numbers.
171	Appendix C, 6.2.2, pg 311	Rates and Payments	Will capitation rates vary by MCO based on the amounts included in the cost component of the proposal? If so, will they rely directly on the assumptions submitted by the MCO in the cost proposal? If the rates will vary by MCO, for what period will plan-specific rates apply? How will MCO-specific cost elements be handled for SFY 2021 and beyond?	The SFY 2020 capitation rates will not vary by MCO for reasons other than risk adjustment. DHHS and its actuaries may use information provided by Respondents in aggregate to develop certain assumptions for the SFY 2020 capitation rates. Please refer to the published SFY 2019 rate reports for the detailed capitation rate development methodology used by DHHS and its actuaries.
172	Appendix C, 3.10.3, pg 43	Program Integrity	Does DHHS have a prescribed form on which the MCO is to submit its ownership & control disclosures?	There is not a prescribed form independent from the group application. DHHS references the group application and utilizes the same ownership and disclosure questions for the MCOs.
173	Appendix C, 3.13.3.1, pg 52	Appeals	Does the requirement to forward the types of grievances listed in Section 3.13.3.1 of the Model Contract (discrimination related to race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual or affectional orientation, physical or mental disability, or gender identity) relieve the MCO of any responsibility for conducting an investigation into and resolving such grievances?	No.
174	Appendix C, 3.15.3.1.18, pg 66	Staffing	The Prior Authorization Coordinator listed in 3.15.3 On-Site Presence is not listed in 3.15.1 Key Personnel. Should the Prior Authorization Coordinator be listed and defined in 3.15.1 Key Personnel?	Refer to Addendum #1.
175	Appendix C, 4.3.6, pg 97	Enrollment	Please describe specifically how a new MCO will achieve critical mass and an equitable share of members if the two incumbent MCOs are awarded contracts?	The program structure implemented by DHHS to meet its commitment to providing new entrant(s) with the ability to achieve an equitable share of MCM Members within twelve (12) to eighteen (18) months of program (as described in Section 2.2.2.1 of the RFP and 5.2.1 of Appendix D) will vary based on the MCOs selected; DHHS anticipates working collaboratively with selected MCOs to meet this commitment and will provide further information when available.

Official Questions Answers for
RFP-2019-OMS-02-MANAG
Medicaid Care Management Services

ID	Reference	Category	Respondent Question	DHHS Response
176	Appendix C; SFY19 MCM Rating Document, 4.2.2; Pharmacy Rebate Adjustment Section, pgs 85; 27	Rates and Payments	On page 27 of the SFY19 MCM Rating Document the Pharmacy Rebates Adjustment section mentions MCOs starting to manage the PDL. Can you clarify what that means and how that relates to Section 4.2.2 of the Model Contract?	Effective 10/1/2015, PDL development transitioned to the MCOs from the DHHS developed PDL. Effective 7/1/2019 the MCOs will follow the DHHS developed PDL.
177	Appendix D, Q#56, pg 26	Technical - RFP	Q1 - Is Question 56 a network-related question (wherein the State is asking respondents about their network "capacity" to provide the mental health services required in the model contract), Q2 - or is the State asking respondents to describe how they intend to provide mental health services?	The question is related to how Respondents will ensure they have the infrastructure and available service array to meet the needs of members as outlined in the Model Contract.
178	Appendix D, Q#58 part 4, pg 27	Technical - RFP	The last sentence in Part 4 of Question 58 reads: "Describe the Respondent's strategies and actions it will utilize to increase suicide prevention awareness and promote suicide prevention programs broadly in New Hampshire." Should this sentence be deleted, since it is also Question 59?	No. Question 58(4) refers to collaboration and coordinated effort with CMH Programs/ CMH Providers (or similar provider) concerning suicide prevention awareness and promotion of suicide prevention programs. Question 59 refers to the respondent's strategies and actions conducted independently from CMH Programs/ CMH Providers that it will utilize to increase suicide prevention awareness and promote suicide prevention programs broadly in New Hampshire.
179	Appendix D, Q#73, pg 32	Technical - RFP	To provide the State a fair and efficient method to compare HEDIS and CAHPS results across bidders, can the State provide a template for presentation of the information being sought from respondents?	MCOs should provide a print-out of the most recent NCQA Health Insurance Plan Ratings found at: http://healthinsuranceratings.ncqa.org/2017/Default.aspx. Print outs should be legible and include the detailed scores for each category (i.e. Customer Satisfaction, Prevention, and Treatment). Do not provide only the aggregate score for each category.
180	Appendix E, Q#105, pg 1	Cost Component - RFP	Question 105 reads… "For each of the managed care strategies proposed by the Respondent..., quantify the estimated reduction in overall per member per month (PMPM) service cost resulting from successful…strategies to reduce service utilization and/or move care to more cost-effective settings." Q1 - Will respondents be required to provide an estimated reduction in PMPM for EACH separate managed care strategy reflected in Sections 10, 12 and 13, Q2 - or is the state requesting an overall estimated PMPM reduction as a result of all care management strategies? Q3 - Should cost reductions be estimated for each year of the contract?	Estimates should be provided in aggregate for each managed care strategy item described in Sections 10, 12, and 13, and reflect full implementation of the respondent's managed care strategy regardless of the time needed to fully implement. If available, comments related to the time needed to fully implement and any differences by population (MCM, Medically Frail, Granite Advantage) are welcome, but not necessary.
181	Appendix E, 6.5 Cost Component, pgs 1-5	Cost Component - RFP	The Hospital Provider Manual, Volume 2, Dated 12/1/2017 (page 10-5) indicates that Outpatient Hospital interim payments are based on percent of charges with final payment based on a percent of costs which are cost settled by the Department. Will the State provide the interim outpatient hospital payment rates currently in effect for the hospitals?	Interim rates are based on prior periods therefore DHHS is not providing this data.
182	Appendix E, 6.5 Cost Component, pgs 1-5	Cost Component - RFP	Will the State please confirm that the Department's cost settlements with the hospitals include final payment for the MCOs?	DHHS' cost settlements are specific to FFS payments. MCO settlements to providers are based on the MCO's contract with the respective providers.
183	Appendix E, 6.5 Cost Component, pgs 1-5	Cost Component - RFP	Alternatively, if the MCOs are required to participate in cost settlement with the hospitals, will the State please clarify how this process works and provide historical experience on the amounts of these settlements?	MCOs contract with providers independently of DHHS arrangements and are not required to use current DHHS FFS payment methodologies.

Official Questions Answers for
RFP-2019-OMS-02-MANAG
Medicaid Care Management Services

ID	Reference	Category	Respondent Question	DHHS Response
184	Appendix E, 6.5 Cost Component, pgs 1-5	Cost Component - RFP	The Hospital Provider Manual, Volume 2, Dated 12/1/2017 (page 10-5) indicates that Laboratory Services provided as part of an Outpatient Hospital or RBC-HB visit are reimbursed through an add-on fee which are paid in addition to the percentage of cost payment for outpatient visits. Reimbursement will be according to the Fee for service rates established for the HCPC procedure codes and are final and not subject to cost settlement. Will the State provide these Laboratory Services fee schedule rates?	Medicaid's Fee-for-Service Fee Schedules are updated at the start of each calendar year on the MMIS portal's main page, under Documents and Forms/Fee Schedules. All lab codes are included on this fee schedule.
185	Appendix E, 6.5 Cost Component, pgs 1-5	Cost Component - RFP	Will DHHS provide a breakdown of points per question for the Mandatory Responses to Cost Components of the RFP (similar to the Technical Proposal questions in Appendix D)?	See RFP Figure 4 Cost Components Evaluation Criteria.
186	Appendix E, Q#115, pg 3	Cost Component - RFP	Q1 - Should the reference to Section 17 of Appendix E be corrected to refer to Appendix D? Q2 - And should the reference to Question 76 be corrected to refer to Question 78 (which also relates to prior experience with APMs as called for under Question 115)?	Refer to Addendum #1.
187	Appendix E, Q#120, pg 4	Cost Component - RFP	Q1 - For question 120, is the state requesting a response that indicates dollars saved as a result of member education and incentives and not a reduction in utilization percentages? Q2 - Also, should this reference to Appendix E be corrected to refer to Appendix D?	Q1 - Respondent should provide answers to Q120 on a PMPM basis. Q2 - Refer to Addendum #1.
188	Appendix E, Q#126, Part 2a, pg 4	Cost Component - RFP	Q1 - Should anticipated costs associated with future delegated local care management be included in local NH MCO staff expenses as referenced in Question 126, Part 2a? Q2 - If no, in which category should it be included?	Anticipated costs associated with future delegated local care management should be reported in the column for the local New Hampshire staff. Respondents should include a description of the treatment of Local Care Management entity costs in the narrative description requested in Part 3 of Question 126 in Appendix E.
189	Draft MCM Withhold and Incentive Guidance; 6.9.2 Draft MCM Withhold and Incentive Guidance, pgs 1-7	Rates and Payments	This document is titled "Draft MCM Withhold and Incentive Guidance" - Will a final version of the withhold and incentive document, including the Minimum Performance Standards in Figures A and C, be made available before the proposal deadline?	The final Withhold and Incentive Guidance is available as a reference document to the RFP on the Department website: https://www.dhhs.nh.gov/business/rfp/rfp-2019-oms-02-manag.htm
190	Draft MCM Withhold and Incentive Guidance, 3.2.3.3, pg 6	Rates and Payments	Will DHHS provide an illustrative example of the Earned Withhold Performance Calculation?	No.
191	General	Enrollment	MCOs that are new to the program are likely to have a disproportionate share of new members with limited experience. Given this likelihood, how will risk scoring be handled if a significant portion of an MCO's enrollment does not have the historical enrollment and claims history necessary to support the development of risk scores?	In the absence of claims data, DHHS recognizes that the MCO will not be able to utilize predictive modeling to identify future high cost members. The MCO will have to utilize other methods and tools to identify high need, high risk members.
192	General	Risk Management	New MCOs will be taking on significant risk due to the expansion population transitioning into managed care and a likely disproportionate share of new members. Is DHHS willing to implement a risk corridor or other risk mitigation strategy to help limit the risk to a new MCO in the early durations of the contract?	DHHS is considering a risk corridor for the Granite Advantage population similar to the risk corridor currently in place for the New Hampshire Health Protection Program populations.
193	RFP 2.3.1, Figure 2, pg 10	Care Management	Section 2.3.1, Figure 2 of the RFP states “MCOs are expected to use Local Care Management Entities to deliver Care Management to at least fifty percent (50%) of high-risk/high-need Members enrolled in Care Management” and Section 2.1.57 of the Model Contract (definition of “Local Care Management”) and Sections 4.10.8.3 and 4.10.3.4 of the Model Contract suggest that MCOs may provide Local Care Management directly and not necessarily through a third party. Is the MCO required to use Local Care Management Entities to deliver Local Care Management?	MCOs are responsible for developing a local care management structure and are encouraged to utilize the existing local case management infrastructure in place to carry out these functions.

Official Questions Answers for
RFP-2019-OMS-02-MANAG
Medicaid Care Management Services

ID	Reference	Category	Respondent Question	DHHS Response
194	RFP, 4.18, pg 28	Technical - RFP	Section 4.18.1 details how successful Respondents will be notified of an award; what notification will unsuccessful respondents receive – especially if not selected for contract negotiation?	See Section 4, Proposal Process, Subsection 4.18.1. Typically, until the State successfully completes negotiations with the selected Respondent(s), all submitted Proposals remain eligible for selection by the State.
195	RFP, 5.1.3, pg 30	Technical - RFP	Q1 - Would DHHS consider allowing larger attachments to be submitted electronically in lieu of a hard copy? Q2 - If yes, will a page threshold be set for documents that can be submitted electronically (e.g., larger than 10 pages)?	No.
196	RFP, 5.2.2, pg 31	Technical - RFP	Is the requested appended material required to be placed in a particular location in the proposal?	No. See Section 5, Proposal Requirements, Subsection 5.2, Technical Proposal Special Instructions and Page Limits, Paragraph 5.2.2.
197	RFP, 5.2.2, pg 31	Technical - RFP	Will DHHS consider requiring that all requested appended material appear immediately following the question to which it relates (rather than compiled at the end of a section or elsewhere in the response), to help the reviewer quickly refer to the appended materials?	Refer to the response in Line ID 196.
198	RFP, 5.3.1.2.3, pg 34	Technical - RFP	Section 5.3.1.2.3 of the RFP asks for information on the “fiscal agent” of the organization. We are familiar with the term as it applies to Medicare and Medicaid providers, but not in the context of an MCO that has not yet commenced operation in the state; as such, what “fiscal agent” is DHHS referring to in this requirement?	Respondents must identify the name, title, mailing address, telephone number and email address of the fiscal agent of the responding organization. In this context, DHHS needs the contact information of the Chief Financial Officer, or similar entity.
199	RFP, 5.3.1.3.1.4, pg 35	Technical - RFP	Section 5.3.1.3.1.4 reads “Shows the Respondent’s overall design of the project in response to achieving the deliverables as defined in this RFP”, Q1 - did DHHS mean to state “design of the program”? Q2 - If no, could you please provide the definition of “design of the project”?	Refer to Addendum #1.
200	SFY19 MCM Rating Document, Risk Adjustment of Capitation Rates Section, pg 8	Rates and Payments	Will risk scoring for the SFY20 rates rely on a similar methodology as described in the SFY19 rate development documents?	Yes, there are no plans to significantly change the risk adjustment methodology at this time.
201	SFY19 MCM Rating Document, Appendix J, PDF page 221; labeled page 1	Pharmacy	Are any changes anticipated to the NDC list for carved out specialty drugs provided in Appendix J of the SFY19 MCM Rating Document?	The final list of carved out drugs has yet to be determined.
202	RFP Section 4.13 Public Disclosure, pg 27	Technical - RFP	RFP page 27 of 41, Section 4.13 states: “The Respondent must clearly identify in writing the information it claims to be confidential and explain the reasons such information should be considered confidential. This should be done by separate letter identifying by page number and proposal section number the specific information the Respondent claims to be exempt from public disclosure pursuant to RSA 91-A:4, I or RSA 91-A:5." Where should this letter be located in the response?	See Section 4, Proposal Process, Subsection 4.13, Public Disclosure, Paragraph 4.13.3. This request must be made in writing and provided separately.
203	RFP Section 5.1.2. Presentation of Submissions, pg 30	Technical - RFP	RFP page 30 of 41, Section 5.1.2.4 states: "The Respondent shall use standard eight and one-half by eleven inch (8 ½” x 11”) white paper." Will DHHS consider allowing 11"x17" sized paper for larger charts to ease legibility?	Yes. However, any larger paper used must have the ability to be folded into the 8 1/2" X11" size and fit into the bound original and copies.
204	RFP Section 5.1.2. Presentation of Submissions, pg 30	Technical - RFP	RFP page 30 of 41, Section 5.1.2.5 states: "The Respondent shall use Arial font size 12 or larger for all narrative responses. Text included as part of a graphic, table, chart, or otherwise identified by DHHS as permissible to append to the Respondent’s Proposal may be in size 10 font." Would DHHS consider 8pt font for process and org charts to help reduce the overall size of the graphics?	Yes.

ID	Reference	Category	Respondent Question	DHHS Response
205	RFP Section 5.3 Outline and Detail, pg 34	Technical - RFP	RFP page 30, Section 5.1.3.2 states: "The original Transmittal Cover Letter (described in Section 5.3.1.2) must be the first page of the Technical Proposal and marked as "Original." However, RFP page 34, Section 5.3.1.2 has the Transmittal Letter coming after the Table of Contents. Should the Transmittal letter be the first page of the Technical proposal or after the TOC?	The Table of Contents, which is a reference table, identifies where to find different documents in the proposal. The first page of the proposal is the Transmittal Cover Letter.
206	Appendix C, Section 4.17.5 Web Access and Use By Providers and Members, pg 270	Privacy and Security	Appendix C, Section 4.17.5.2.6 states: "The website shall provide an e-mail link to the MCO to allow Providers and Members or other interested parties to e-mail inquiries or comments." Must the communication channel be via email, specifically, or is secure electronic messaging functionality acceptable?	Website requirements will be part of readiness review.
207	General Question	Technical - RFP	In an effort to be environmentally friendly and reduce the amount of paper used in responses, would DHHS consider allowing MCO's to submit any required documentation that is over 10 pages to be provided electronically only?	No.
208	Appendix C, Section 4.10.8 Local Care Management, pg 183	Care Management	In the "REQUEST FOR PROPOSALS RFP-2019-OMS-02-MANAG FOR MEDICAID CARE MANAGEMENT SERVICES" document on page 10 of 41, there is a stated requirement that "MCOs are expected to use Local Care Management Entities to deliver Care Management to at least fifty percent (50%) of high-risk/high-need Members enrolled in Care Management." However, Appendix C, 4.10.8.2 Local Care Management (page 183) states that "The MCO will design an effective Local Care Management structure for fifty percent (50%) of high-risk or high-need Members, including those who are medically and socially complex or high utilizers." [Continued in next record]	Refer to the response at Line ID 209.
209	Appendix C, Section 4.10.8 Local Care Management, pg 183	Care Management	[Continued from previous record] Q1 - Is the expectation for the MCO to have at least 50% of high-risk or high-need members in a Local Care Management structure that can be provided by the respondent or can be designated to a Local Care Management Entity (see definition below) Q2 - or is it a requirement that at least 50% of our Local Care Management structure be designated to a LCME? 2.1.37.1 "Designated Local Care Management Entities" means Integrated Delivery Networks (IDNs) that have been certified as Designated Local Care Management Entities by DHHS; Health Homes, if DHHS elects to implement Health Homes under the Medicaid State Plan Amendment authority; and other contracted entities capable of performing Local Care Management for a designated cohort of Members, as determined by DHHS.	MCOs are responsible for developing a local care management structure and are encouraged to utilize the existing local case management infrastructure in place to carry out these functions.
210	Appendix C, Section 4.4.1.4.4.2 - Member Handbook Dissemination, pg 106	Covered Services	Section 4.4.1.4.4.2. states: "The MCO shall advise the Member in paper or electric form that the Member Handbook information is available on the internet, and include the applicable internet address, provided that Members with disabilities who cannot access this information online are provided Auxiliary Aids and services upon request at no cost. [42 CFR 438.10(d)(3)]" When looking at the term "Auxiliary Aid" the definition seems broader than what is typically provided by a MCO: "2.1.10.1 "Auxiliary Aids" means services or devices that enable persons with impaired sensory, manual, or speaking skills to have an equal opportunity to participate in, and enjoy the benefits of programs or activities conducted by the MCO. Such aids include readers, Braille materials, audio recordings, telephone handset amplifiers, telephones compatible with hearing aids, telecommunication devices for deaf persons (TDDs), [Continued in next record]	Refer to the response at Line ID 212.

Official Questions Answers for
RFP-2019-OMS-02-MANAG
Medicaid Care Management Services

ID	Reference	Category	Respondent Question	DHHS Response
211	Appendix C, Section 4.4.1.4.4.2 - Member Handbook Dissemination, pg 106	Covered Services	[Continued from previous record] interpreters, note takers, written materials, and other similar services and devices." Subsequent sections within the Model Contract reference specific items that we are accustomed to providing - 4.4.2.5 (large print) 4.4.2.9 (TTY and ASL interpreters); however, a review of the referenced administrative code includes language that would indicate a requirement to provide specific auxiliary aids: "Require each MCO, PIHP, PAHP, and PCCM entity to make its written materials that are critical to obtaining services, including, at a minimum, provider directories, enrollee handbooks, appeal and grievance notices, and denial and termination notices, available in the prevalent non-English languages in its particular service area. Written materials must also be made available in alternative formats upon request of the potential enrollee or enrollee at no cost. [Continued in next record]	Refer to the response at Line ID 212.
212	Appendix C, Section 4.4.1.4.4.2 - Member Handbook Dissemination, pg 106	Covered Services	[Continued from previous record] Auxiliary aids and services must also be made available upon request of the potential enrollee or enrollee at no cost. Written materials must include taglines in the prevalent non-English languages in the state,as well as large print, explaining the availability of written translation or oral interpretation to understand the information provided and the toll-free and TTY/TDY telephone number of the MCO's, PIHP's, PAHP's or PCCM entity's member/customer service unit. Large print means printed in a font size no smaller than 18 point." Q1 - Can DHHS please confirm that the definition of Auxiliary Aids includes those items that are required to be provided at no cost to the enrollee, including large print, braille, TTY, and interpreter services?	The auxiliary aids and services requirements are as described.
213	Appendix C, 4.3.2 MCO Role in Work and Community Engagement Requirements, pg 93	Technical - Contract	Section 4.3.2.1 states: "The MCO shall support the implementation and ongoing operations of the work and community engagement eligibility requirements for certain Granite Advantage Members, including but not limited to the activities described in Section 4.3.1.1.1 (General Outreach and Member Education Activities) through 4.3.1.1.4 (Status Tracking and Targeted Outreach) of this Agreement." However, the sections referenced 4.3.1.1.1 & 4.3.1.1.4) are not found in the current Appendix C: MCM Model Contract. Can DHHS please confirm the reference should be to 4.3.3 and 4.3.3.2.3?	Refer to Addendum #1.
214	Appendix C, 4.3.3 General Outreach and Member Education Activities, pg 95	Granite Advantage	Appendix C, Section 4.3.3.2.2.5.states: "The MCO shall transmit to DHHS, through a mechanism to be specified by DHHS, information for Members who are exempt or may be exempt. The MCO shall indicate to DHHS that the Granite Advantage Member is potentially exempt from work and community engagement requirements if, based on the MCO's claims analysis, physician certification, and/or Care Management data, the MCO can determine that the Member is exempt. The MCO shall indicate that the Member is potentially exempt if the MCO has determined that the individual meets the criteria for a diagnosis-based exemption, but the MCO has not been able to obtain the required physician certification." [Continued in next record]	Refer to the response at Line ID 215.
215	Appendix C, 4.3.3 General Outreach and Member Education Activities, pg 95	Granite Advantage	[Continued from previous record] This reads as if the MCO would transmit a file to DHHS that would have two cohorts – those that are potentially exempt (appear to meet based on diagnosis but no MD certification) and those that are exempt (have MD certification). Is it correct to assume that MCOs do not make decisions regarding exemption status and all members are to be presumed "potentially exempt," but MCOs are to include an indicator on such reporting of where a MD certification was able to be obtained?	MCOs do not make decisions regarding exemption status. DHHS readiness review will further define MCO requirements.

Official Questions Answers for
RFP-2019-OMS-02-MANAG
Medicaid Care Management Services

ID	Reference	Category	Respondent Question	DHHS Response
216	Appendix D, Section 15 Quality Management, Q #73, pg 32	Technical - RFP	For new potential entrants who do not have NH HEDIS scores but have affiliates in other markets, will DHHS please confirm it is acceptable to select three representative markets in answering this question?	DHHS will accept three representative markets.
217	Appendix C, Section 4.13.3 Provider Screening, Credentialing and Re-Credentialing, pg 236	Network Management	Appendix C, Section 4.13.3.5.4.3 states: "For Providers not currently enrolled with NH Medicaid, the MCO shall…educate prospective Participating Providers on optional Member treatment and payment options while credentialing is underway, including…an opportunity for the Provider to accept a level of risk to receive payment after affirmative credentialing is completed in exchange for…compliance with network requirements and practices." Q1 - Can DHHS please clarify what is the level of risk that the Provider would be agreeing to accept? Q2 - Does this require the MCO to make payments to prospective Providers who have not yet completed the MCO credentialing process? Q3 - Is the MCO required to recoup any such payments if the provider does not successfully complete the credentialing process?	An MCO must afford an opportunity to provide payment to a provider that is contingent upon credentialing.
218	Appendix C, Section 4.13.3 Provider Screening, Credentialing and Re-Credentialing, pg 236	Network Management	Q1 - Can DHHS please clarify the meaning of "opportunity for the Provider to accept a level of risk to receive payment after affirmative credentialing is completed in exchange for the prospective Participating Provider's compliance with network requirements and practices"? Q2 - Additionally, please provide the requirement of the MCO?	An MCO must afford an opportunity to provide payment to a provider that is contingent upon credentialing.
219	Appendix C, Section 4.10.5 Comprehensive Assessment for High-Risk and High-Need, pg 177	Care Management	The following two items appear to be in conflict with one another. Section 4.10.5.1 states: "The MCO and its Subcontractors shall implement mechanisms to conduct a Comprehensive Assessment for each Medicaid Member in order to identify whether they have Special Health Care Needs and any on-going special conditions that require a course of treatment or regular care monitoring." Section 4.10.5.2 states: "The MCO shall identify Members who may require a Comprehensive Assessment for Care Management through multiple sources to include but not be limited to:…." Section 4.10.2.1 states: "The Health Risk Assessment screening process shall identify the need for Care Coordination and Care Management services and the need for clinical and non-clinical services including referrals to specialists and community resources." [Continued in next record]	Refer to the response at Line ID 220.
220	Appendix C, Section 4.10.5 Comprehensive Assessment for High-Risk and High-Need, pg 177	Care Management	[Continued from previous record] Our expectation is that all members will receive (or be attempted) an Initial Health Risk Assessment Screening to determine their appropriateness for Care Management along with our specific risk stratification analytics. Can DHHS please confirm that the Comprehensive Assessment is only required for those members identified as needing Care Management based on the Initial Health Risk Assessment Screening?	The Comprehensive Assessment is required if a member is identified as being part of one or more of the priority populations, identified through risk scoring and stratification or having been referred for care management.
221	Appendix D, Section 1 Organization Overview and Overview of Relevant Experience, Question 7, pg 3	Technical - RFP	May organizational charts be submitted on 11x17 size paper to make them easier to read?	Refer to the response at Line ID 203.
222	Appendix C, 4.3.4 Member Enrollment and Disenrollment, pg 68	Enrollment	Q1 - Would DHHS provide bidders with the percentage of enrollees that self-select versus who are auto assigned? Q2 - Additionally does DHHS have program wide member projections for the contract period?	Q1 - No. Q2 - Figure 1 on Page 7 of the RFP represents DHHS' best current estimate of total managed care membership for July 2019. DHHS does not have projections for the five year life of the contract period.

Official Questions Answers for
RFP-2019-OMS-02-MANAG
Medicaid Care Management Services

ID	Reference	Category	Respondent Question	DHHS Response
223	Subcontractor Sample Monitoring Reports, pg 5	Technical - RFP	Per Appendix D, Question 10, items 5 and 6, can DHHS please confirm if Bidders are expected to submit sample reports that Subcontractors use to monitor the performance of downstream/lower tier subcontractors/Providers?	Yes.
224	Special Instructions/Page Limits, pg 31	Technical - RFP	Per Appendix D, Question 10, can DHHS please confirm that the attachment of applicable licenses does not count toward the 8-page limit?	Confirmed.
225	Appendix E, Cost Component Points, pg 1	Cost Component - RFP	Q1 - How will the points be awarded for the various cost component questions about managed care savings, TPL, program integrity, and administrative costs be awarded? Q2 - Will the respondents with the highest savings and lowest costs be awarded the most points?	See RFP Figure 4 Cost Components Evaluation Criteria.
226	General Question	Rates and Payments	For the Medicaid expansion membership that will be under managed care starting 1/1/19, can DHHS provide information on the expected claims/premium levels for these members and how these members' rates will be determined since the rates are not included in SFY'19 rate development?	CY2016 and CY2017 Premium Assistance Program (PAP) Cost Models is available as a reference document to the RFP on the Department website: https://www.dhhs.nh.gov/business/rfp/rfp-2019-oms-02-manag.htm
227	Appendix E, Managed Care Cost Savings Estimates	Cost Component - RFP	Can DHHS please provide claims level data and membership data for Medicaid and expansion members at the member level to provide an estimate on the amount of savings to expect, for incurred dates of calendar year 2017 paid through August?	DHHS will not provide member level data as part of the RFP process.
228	Appendix D, Section 19 Claims Quality Assurance and Reporting, pg 38	Technical - RFP	Appendix D, Questions 83, 85, and 87, asks for three items: 83) quality control procedures that ensure the Respondent's encounters are accurate 85) three (3) years of Encounter Data submission compliance ratings for one Medicaid contract, and 87) a table listing all instances in the last five (5) years and for all Medicaid managed care contracts in which the Respondent was: (1) delayed in submitting Encounter Data; (2) unable to submit Encounter Data; and/or (3) otherwise out of compliance with a state's requirement to provide Encounter Data. As there is a 5 page limit for Section 19, can DHHS please confirm that Respondents may attach documentation to fulfill the requirements for items 2 and 3, and that the attachments do not count against the 5-page limit?	Confirmed.
229	Appendix D, Section 4.1 Covered Populations and Services, pg 7	Technical - RFP	Can DHHS provide Attachment A, (Covered Services Document)?	There is no reference to Attachment A Covered Services document in the RFP.
230	Appendix C, 4.1.2 Overview of Covered Services, pg 71	Covered Services	There is a reference in Section 4.1.2 of the MCM (Exhibit A) to coverage of Applied Behavioral Analysis (ABA) Services. Can DHHS please provide additional guidance (e.g. service definitions, amount duration and scope, etc.) on ABA requirements, to include treatment of Autism Spectrum Disorder (ASD)?	Currently, DHHS provides coverage for ABA under provisions of EPSDT. Services are provided to children under the age of 21 years who have a diagnosis of autism. Decision-making around amount, duration and scope is based on medical necessity.
231	Appendix C, Section 4.11 Behavioral Health, pg 191	Rates and Payments	DHHS has outlined 2 different payments mentioned in sections 4.11.1.1/.2/.4 – a Capitation payment and a Prospective Payment process. We understand the prospective payment process has specific services not part of the Capitation payment. Can DHHS provide additional guidance on how these payment types work in conjunction with one another and the services under each?	The administration of the capitation contracts follows a prospective capitation payment methodology for contractually defined categories of service that are billed with a defined billing modifier, services outside those categories are paid fee-for-service.

Official Questions Answers for
RFP-2019-OMS-02-MANAG
Medicaid Care Management Services

ID	Reference	Category	Respondent Question	DHHS Response
232	Appendix D, Section 12 Care Coordination and Care Management, Q #49, pg 21	Care Management	Q1 - Will Designated Care Management Entities be required to obtain certification or accreditation as a case management organization? Q2 - Can DHHS provide the process for doing so?	Only IDNs will be required to obtain certification from DHHS as a Local Care Management entity. The process to be undertaken is under review and discussion.
233	Appendix D, Section 17 Alternative Payment Models, pg 34	Technical - RFP	The requirements specified in Appendix D, Section 17, for submission of the Respondent's APM Implementation Plan refer to and incorporate the requirements for APM Implementation Plans specified in the MCM Contract Section 4.14 which are far more extensive, and the language is significantly different from what is specified in Appendix D, Section 17. Can DHHS clarify which set of requirements will govern this and other sections of the RFP response?	An MCO should directly address the questions in the RFP and Appendix D and E. (Appendix C reflects the full contractual obligations).
234	Appendix D, Section 13 Behavioral Health (Mental Health and Substance Use Disorder), Q #57, pg 55	Network Management	Appendix D, Question 57, states that the MCO is to employ clinical Providers with admitting privileges at each hospital in the state who can provide on-site psychiatric assessments, treatment, prescribing, care coordination, and discharge planning for Members at risk of psychiatric boarding. In addition, this section refers to an on-site liaison with privileges at the hospital to continue Members' care management. Q1 - Will DHHS please confirm that MCOs could fulfill this requirement by contracting with Providers with admitting privileges rather than employing staff? Q2 - Will DHHS please confirm that the on-site liaison should have access, rather than privileges, to continue the Member's Care Management?	Q1 - Refer to Appendix C Section 4.11.5.17.1. Q2 - Refer to Appendix C Sections 3.15.2.3 and 4.11.5.18.2.2.
235	RFP Section 2.3.1 Care Mgmt, pg 10	Technical - RFP	Section 2.3.1 states that, "Care Management for high-risk/high-need Members must be provided to at least fifteen percent (15%) of an MCO's Members or the MCO must provide to DHHS documentation of why fewer Members require such services, which will be subject to DHHS approval." Please clarify whether the definition of Care Management would include service or care coordination provided by any staff member, such as a housing coordinator, member call staff, care coordination staff, gaps in care, or clinic day coordination by QM staff?	Providing assistance with social determinants of health such as housing would qualify as a care management service. One time (point in time) interventions by call center staff, care coordination staff, or clinic day coordination by QM staff does not meet the definition of care management unless a plan of care is developed and follow up is scheduled to assure the member's identified needs are being met.
236	Appendix C, Section 4.2 Pharmacy Mgmt, pg 84	Pharmacy	With reference to Appendix C, Section 4.2.1, can DHHS provide the list of carved-out drugs, if any?	The current NDC list of carved out drugs is in the SFY 2019 MCM Rating Document- Appendix J. These include drugs to treat Hepatitis C and hemophilia (POS claims only), and the drugs Carbaglu and Ravicti.
237	Appendix C, Section 4.2 Pharmacy Mgmt, pg 89	Pharmacy	Please clarify the definition of 5 drugs; are MCOs to count all drugs or maintenance drugs only? A patient can be on 5 drugs during a 60-day period to treat temporary and transient illness, such as, a very bad cold, or itchy/allergic skin.	The MCOs are to count drugs taken continuously for at least 60 days.
238	Appendix D, Section 15 Quality Management, Q #73, pg 32	Technical - RFP	Can DHHS confirm if the Responder's response to Appendix D, Question #73, should be embedded within the Technical Response or as an Appendix?	Embedded within the Technical Response.
239	Appendix C, Section 4.1 Covered Populations, pgs 68-74	Covered Services	Section 4.1 (Covered Populations) – Page 68-74, shows Family Planning Benefit is covered by DHHS however in Section 4.1.2 (Overview of Covered Services) it has Family Planning listed as an MCO covered service. In addition, Section 4.7.2 (Assurances of Adequate Capacity and Services) stipulates the requirement for the MCO to include sufficient family planning providers. Can DHHS please clarify the MCO's role in providing Family Care benefits and whether or not this specialty impacts network adequacy?	The MCO is responsible for assuring members have timely access to a full range of family planning services including a sufficient number of providers to deliver this care.

Official Questions Answers for
RFP-2019-OMS-02-MANAG
Medicaid Care Management Services

ID	Reference	Category	Respondent Question	DHHS Response
240	Appendix C, Section 4.7.2 Assurances of Adequate Capacity and Services, pg 143	Network Management	In Section 4.7.2 (Assurances of Adequate Capacity and Services) – Page 143, to assure network adequacy, State is to provide a member report "NH MCM Fifty Percent (50%) Population Estimate by Zip Code" (Section 4.7.2.5). Will this be provided by DHHS?	NH MCM Fifty Percent (50%) Population Estimate by Zip Code is available as a reference document to the RFP on the Department website: https://www.dhhs.nh.gov/business/rfp/rfp-2019-oms-02-manag.htm
241	Appendix C, Section 4.7.3 Time and Distance Standards, pg 143	Network Management	Section 4.7.3 (Time and Distance Standards) Page 143-144 – The specialty categories provided in this section does not align with the Prov Type category in the state provider file that was provided. Will DHHS be issuing a specialty crosswalk to ensure MCO's are categorizing specialty types per State requirements for network adequacy reporting?	DHHS does not plan to submit a crosswalk at this time.
242	Appendix C, Section 4.7.3.4 Additional Provider Standards, pg 144	Network Management	Section 4.7.3.4 (Additional Provider Standards) Page 144-145, will DHHS provide a listing of providers that specifically meet specialty categories as identified in this Section (MLADCs, OTPs, Buprenorphine Prescribers, Residential Substance Use Disorder Treatment Programs and Peer Recovery Programs)?	For all licensed individuals and facilities within the state, please go to: https://nhlicenses.nh.gov/verification/Search.aspx?facility=N. Another helpful resource is: https://www.oplc.nh.gov/alcohol-other-drug/. Buprenorphine information is best collected from SAMHSA.
243	Appendix D, Section 17 Alternative Payment Models, Q #77, pg 35	Technical - RFP	Appendix D, Section 17, Question 77 (6), states: For all proposed APM models included in the Respondent's APM Implementation Plan, clearly articulate how the Respondent will be transparent both in contracting with Providers and with DHHS on all elements of the Respondent's APM offerings, including: (6) By providing a sample reporting template that will be shared with Provider APM participants to support concurrent utilization management as well as retrospective information for the development of an performance under the MCO's proposed APM models There appears to be language missing in the sentence "…development of an performance…" Can DHHS please provide clarification of this question?	Refer to Addendum #1.
244	4.3 Member Enrollment and Disenrollment, RFP pg 12	Enrollment	The state has identified that it plans to achieve equal membership distribution across MCOs. In a scenario where incumbent plans are awarded contracts under this current RFP. How does the state intend to achieve equal distribution, given that the auto-assignment algorithm honors previous MCO assignment and the current enrollment timeline would delay any enrollments to a new plan until after the initial assignments for the program?	The program structure implemented by DHHS to meet its commitment to providing new entrant(s) with the ability to achieve an equitable share of MCM Members within twelve (12) to eighteen (18) months of program (as described in Section 2.2.2.1 of the RFP and 5.2.1 of Appendix D) will vary based on the MCOs selected; DHHS anticipates working collaboratively with selected MCOs to meet this commitment and will provide further information when available.
245	4.3 Member Enrollment and Disenrollment, RFP pg 12	Enrollment	In order for new MCO entrants to evaluate the financial viability of the proposed program, it is critical that the state provide transparency in what is determined to be the minimum enrollment level. Would the state please provide the minimum enrollment level that it considers for financially viable health plan operations?	The program structure implemented by DHHS to meet its commitment to providing new entrant(s) with the ability to achieve an equitable share of MCM Members within twelve (12) to eighteen (18) months of program (as described in Section 2.2.2.1 of the RFP and 5.2.1 of Appendix D) will vary based on the MCOs selected; DHHS anticipates working collaboratively with selected MCOs to meet this commitment and will provide further information when available.
246	4.3 Member Enrollment and Disenrollment, RFP pg 12	Enrollment	Q1 - As recognized by both federal regulations, and in the state's auto-assignment algorithm, continuity of care is one of the primary factors and considerations in the MCO assignment process. Given this priority, would the state please identify how the Medicaid Expansion population's previous MCO assignments will be taken into account during the auto-assignment process? Q2 - For example, if a new MCO that currently participates in the New Hampshire Health Insurance Exchange is awarded a contract through the RFP, but does not "go-live" until the middle of 2019 (after the initial auto-assignment), what opportunity will their previous Exchange members be given to re-enroll with that MCO at that later go-live?	The program structure implemented by DHHS to meet its commitment to providing new entrant(s) with the ability to achieve an equitable share of MCM Members within twelve (12) to eighteen (18) months of program (as described in Section 2.2.2.1 of the RFP and 5.2.1 of Appendix D) will vary based on the MCOs selected; DHHS anticipates working collaboratively with selected MCOs to meet this commitment and will provide further information when available.

Official Questions Answers for
RFP-2019-OMS-02-MANAG
Medicaid Care Management Services

ID	Reference	Category	Respondent Question	DHHS Response
247	4.3 Member Enrollment and Disenrollment, RFP pg 12	Enrollment	Q1 - Will the state consider automatically enrolling those members with their previous Exchange plan in July 2019? Q2 - Will the state please confirm that all members will be given a second open enrollment opportunity in July 2019 if additional plans are going live on that date?	The program structure implemented by DHHS to meet its commitment to providing new entrant(s) with the ability to achieve an equitable share of MCM Members within twelve (12) to eighteen (18) months of program (as described in Section 2.2.2.1 of the RFP and 5.2.1 of Appendix D) will vary based on the MCOs selected; DHHS anticipates working collaboratively with selected MCOs to meet this commitment and will provide further information when available.